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Cour d'Appel

Montréal

En appel de deux jugements rendus le 26 juillet 1991, par l'honorable juge Jean-Jude Chabot, de la Cour supérieure, district de Montréal.

Nos: 500-09-001296-912 C.a.M. - 500-05-009755-883 C.s.M.

LE PROCUREUR GÉNÉRAL DU CANADA
APPELANT-Intimé

c.

RJR-MacDONALD INC.
INTIMÉE-Requérante

-et-

LE PROCUREUR GÉNÉRAL DU QUÉBEC
MIS EN CAUSE-Mis en cause

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IMPERIAL TOBACCO LTD
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LE PROCUREUR GÉNÉRAL DU QUÉBEC
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Le 19 mars 1990 (Suite)

LA COUR:

Avant de recommencer, on a eu déjà deux (2) alertes à la bombe ce matin. Si vous voyez des colis suspects, dites-le vite.

LE GREFFIER:

Ça m'étonnerait, Monsieur le Juge. La salle était sous scellés, sous les mêmes scellés.

CROSS-EXAMINATION BY Me EARL A. CHERNIAK, Q.C. (CONTD), On behalf of Petitioner, RJR-Macdonald Inc.:

Q- Dr. Hancock, you told us about this Advocacy, this Health Advocacy Unit in Toronto. Is that still an ongoing organization?

A- No, it -- it was changed in nineteen eighty-two (1982) to become Central Resources.

Q- But it's -- it may be called something else but it's -- it's...

A- No, the unit doesn't exist any longer.

Q- The unit doesn't exist and hasn't existed since nineteen eighty-two (1982)?

A- That's right.

Q- Well, I wonder if you'd look at an article that you wrote in Community Mental Health Action, edited by Lumsden, published in nineteen eighty-four (1984)? Can you tell me whether you wrote a chapter in that

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publication?

0/0057 A- That's right.

Q- May be this be the next RJR exhibit?

THE CLERK:

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Me CHERNIAK:

Q- And if you look at the chap... is this a chapter in a book or...

A- Yes, it was a book called "Community Mental Health".

Q- Yes, and the heading is "Health as a Social and Political Issue - Toronto's Health Advocacy Unit".

A- I did.

Q- And you say under the heading "A Brief History" on page three twenty-one (321), right at the bottom of the page, you say:

> "It was in response to these needs that the Health Advocacy Unit was created in 1979, based on a consultant's report that was adopted by City Council."

A- M'hm.

Q- And then you talk about its budget and the like.

A- That's right.

Q- And then you deal, in the bulk -- in the balance of the article, to deal with its -- with the structure and function of the unit.

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A- Right.

Q- And you talk about, for instance, at page three twenty-five (325), in the middle of the page, about the longer term of the Health Advocacy Unit. You say:

> "Thus, in the longer term, the Health Advocacy Unit sees mental health as a social and political issue."

And then you conclude...

A- Right.

Q- ... at page three twenty-six (326), you talk about:

> "The Health Advocacy Unit is a unique organization that embodies informational, educational, political and community development skills."

Now, I'm a little -- I'm a little surprised because this was a publication in nineteen eighty-four (1984) and you tell me that this unit that you're describing in such fulsome detail didn't exist? Was that what I would understand?

A- Certainly, by the time the publication came out, the nature of publishing being what it was. The chapter was written probably in nineteen eighty-one (1981).

Q- So you wrote a chapter in nineteen eighty-one (1981)...

THE COURT:

Q- It's probably eighty-two ('82) because you have

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references in eighty-two ('82).

A- Oh, okay. Well, eighty-two ('82).

Me CHERNIAK:

Q- So you allowed this publication to appear in this book in nineteen eighty-four (1984) about an organization that didn't exist anymore? Is that what we're to understand?

A- That's correct, but it was -- yes, it was about the organization and about its issues. It was describing the unit as it was when I wrote it.

Q- But I suppose that people who were reading it in nineteen eighty-four (1984), or reading the passage that I've read to you, would assume that the unit still was operating?

A- They might do.

Q- I see. Okay. At any rate, I want to ask you a few questions about it. Your job with the unit was what?

A- I was the health planner.

Q- You were the health planner, right?

A- That's right.

Q- And you say, at page three twenty-two (322), this:

> "Early in its life, the unit recognized that the problems it seeks to deal with are complex and long lasting and that the social and political solutions of these problems

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ultimately require societal changes which may take many years to achieve. There are no quick fix solutions to problems that have taken years to develop. The 4 major areas of concern were mapped out early on, these were and still are smoking, social factors in ill health, chemical pollution and the inadequacy of existing health data."

A- M'hm.

Q- So is it fair to say that one of the purposes of the unit was to effect or work towards, advocate -- to use the words of the title -- societal and political solutions to these recognized problems?

A- That's right.

Q- Yes. Okay. And if we look at the top of the next page, three twenty-three (323), you deal with the field of smoking on the second line:

"In the field of smoking, this has led us to propose a 20 year program based at the community level and intended to create a generation of non-smokers."

A- Right.

Q- Did you write that?

A- Yes.

Q- So I take it that your agenda, as the health planner for

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that health unit, the agenda of the unit, the Health Advocacy Unit and your agenda as its health planner was to propose a twenty (20) year program based at the community level and intended to create a generation of non-smokers?

A- Yes, that was part of our...

Q- And that's what you were working towards?

A- That's part of our agenda, yes.

Q- And it's still -- and it's part of your agenda?

A- That's part of the public health movement's agenda.

Q- What about you? You're the one that's here?

A- Yes.

Q- Is it part of your agenda?

A- Of course.

Q- And then you say, at the bottom of that page, the last paragraph:

> "Of course, we are dealing with powerful opponents, and it does not pay to underestimate them. In addition, our position is potentially somewhat precarious because we are the servants of political masters and political winds can and do change. While we are attempting to achieve health ends through political means, it's perhaps inevitable that some critics mistakenly believe we're trying

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to achieve political ends through health means."

A- Right.

Q- But you certainly were trying, in the -- with respect to the aims of the Health Advocacy Unit, to use political ends to achieve your goals?

A- No, we were trying to use political means to achieve our goals. That's what that says.

Q- I see. Well, so that you were in part at least a political advocacy group?

A- Of course.

Q- Yes. Okay.

A- That's what public health has been for centuries.

Q- And you -- you say that it's important that you be as sure of your facts as you reasonably can be in achieving those goals, yes?

A- That's right.

Q- And then you quote from George Bernard Shaw and you said:

"The reasonable man seeks to adapt himself to the world, the unreasonable man seeks to adapt the world to himself. Progress therefore depends on the unreasonable man."

And you accept that definition by saying that:

"We ..."

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-- including yourself and the health advocacy unit --

"... intend to go on being unreasonable in this sense."

A- In that sense, yes.

Q- Yes. In other words, seeking to adapt the world to your goals? That's the sense that George Bernard Shaw used it?

A- In the sense of that as opposed to a seeking to adapt oneself to the way the world is.

Q- Well, "the unreasonable man seeks to adapt the world to himself." Your goal was to change the world to achieve your goals. I mean, does it mean anything else?

A- No, I mean, that's what public health has tried to do throughout the centuries, to make the world a better and healthier place.

Q- A political -- it's a political position. Change the world to suit your goals.

A- But as I've explained all along, public health is as much about politics as it is about science.

Q- Yes.

A- Public health is, by its very nature, a political process.

Q- Exactly right. Exactly right.

And in pursuit of these goals, you have proposed something called the "Conserver Society," have you not?

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A- I haven't proposed it, actually, it was proposed by the Science Council of Canada.

Q- Well, you advocate it, though, I take it?

A- Yes, it's actually now, in this day and age, referred to as sustainable development.

Q- Well, I want to find out what you mean by it.

A- Certainly.

Q- I'm showing you a publication called, "Canadian Family Physician," and an article that you wrote. May we make this the next RJR exhibit?

THE GREFFIER:

173.

Me CHERNIAK:

Q- And you wrote this in nineteen eighty (1980)?

A- Well, I probably actually wrote it before, of course, it was published in nineteen eighty (1980).

Q- Yes. And you were dealing with the various alternative public health futures that were open to society, am I correct?

A- Yes, I was dealing with it in the sense of futurism and looking at alternative futures.

Q- Right. And you proposed -- you indicated that there were five (5) possible scenarios.

A- There are commonly five (5) scenarios. I think in this instance I was using the five (5) that James Robertson

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discusses. I mean there is a, as with anything else, there's a range of scenarios in the futures field. This happens to be James Robertson's five (5).

Q- And...

A- It's quite representative of...

Q- And you were advocating, ultimately, one (1) of them?

A- That's correct.

Q- Yes. Well, let's just deal -- let's just find out what the five (5) are and then we'll understand better what you were advocating.

One (1) is: "business as usual." In other words, nothing changes.

A- Right.

Q- And the second is: "the disaster scenario," which you say is frighteningly possible?

A- Yes. And actually ten (10) years later, even more so.

Q- Yes. And you didn't advocate either one of those, the status quo or the road to disaster that we're now on?

A- That's right.

Q- Yes. And the third is totalitarian control, in which authoritarian government limits our insatiable greed.

A- M'hm.

Q- That's the third scenario?

A- Yes.

Q- And I take it you weren't advocating that one either.

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A- That's right.

Q- And the fourth and the fifth are what you call -- are break through scenarios.

A- That's what Robertson called them, yes.

Q- Yes. And one of them involves -- one of them that you don't advocate involves the attempt to control and dominate other men?

A- I'm sorry. Where are you reading that?

Q- The first...

A- Oh, right.

Q- ...around the center of the -- or at least the center column.

A- Well, I'd say you were taking that out of context. I think the...

Q- The first, the break-out future is the one envisaged by Herman Kahn and others.

A- Right. And that's a future based on the notion of domination of nature, and the point I was making is, as William Leiss has remarked, if the idea of the domination of nature has any meaning at all, it is by such means some men attempt to control and dominate other men. In other words, William Leiss was making the point that the domination of nature and the value and ferocity of the domination of nature carries with it the domination of human nature.

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Q- Well, what you say though, at the bottom of the -- about the center column, in medical terms, this is the fourth alternative.

A- Sorry. Oh, yes, okay.

Q- "It is the future of genetic engineering, transplant surgery, nuclear powered hearts, cyborgs, test tube babies, mood and mind control, the conquest of pain and death."

A- Yes.

Q- Yes. And, of course, we do have some of those things, don't we? We have...

A- Oh, undoubtedly.

Q- We have genetic engineering now. We have transplant surgery. We don't have nuclear powered hearts. We have test tube babies. There certainly is some mood and mind control, loss of initiatives towards the conquest of pain and death.

A- M'hm.

Q- So much of that future has, in fact, come to pass, hasn't it?

A- Yes.

Q- Yes. And then you contrast with that future the -- what you call: "The SHE Society." This is at the bottom of the right-hand page.

A- It's actually what Robertson calls: "The SHE Society."

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Q- Oh, I see. Well, you call it: "sane, humane and ecological." That's the -- those are the same terms that you used in another article that we just referred to.

A- Yes. That's right. I was quoting...

Q- So I thought it was you that was saying it.

A- No, I was quoting Robertson there.

Q- And you say that -- at the top of the next page, that this involves a balance within ourselves.

> "Humanity is balance between ourselves and other people and ecology is balance between people and nature."

And I assume these are your words:

> "It is a right-brain holistic intuitive feminine future, and it is this future that I am concerned with."

So that's the future that you, in effect, and people who think like you are advocating?

A- Yes. It's a -- yes.

Q- And I take it that one aspect of such a future, you've listed about halfway down that left-hand column, it's that future opposes agents such as nuclear power.

A- Yes.

Q- And that future, if we look at the bottom of the center column:

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"... that future must lead us to examine carefully the health costs of our society."

A- Yes.

Q- "The use of the environment, our diet, our transportation policy, our advertising practices are not conducive to health."

And I take it those who advocate this as a society must change all those things.

A- Must work towards changing those, yes.

Q- Yes.

A- That's what healthy public policy is about.

Q- And for example, you say:

"A decentralized society would mean that people would live closer to their work."

A- Yes.

Q- Less transportation would be needed.

A- Yes.

Q- And the attendant ills of the automobile would be reduced.

A- Yes.

Q- So you would advocate that people should in fact live closer to their work?

A- That's correct.

Q- Yes.

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be..."

A- What I'm advocating there is that they should live closer to their work and that we need to look at the way we develop our towns and cities so that it's possible for them to live closer to their work.

Q- "And more rational use ..."

-- you say --

"... of agricultural land would require that less meat be consumed."

A- That's right.

Q- "And less land be devoted to tobacco and alcohol substrates."

A- M'hm.

Q- In other words, you would, in effect, require that people eat less meat and use less alcohol and tobacco?

A- Require is the wrong word in that sense. We would encourage...

Q- That's your word, sir. It's your word.

A- I'm sorry. Where are we looking?

Q- "More rational use of agricultural land would require that less meat be consumed."

A- Yes. The point is that the -- it is the rational use of agricultural land that requires that.

Q- Well...

A- In other words, it's not -- the implication of your

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question is that it is -- that we need to require, implying compel people to eat less meat. That is not the point. The point is that if we were to rationally use our agricultural land, that would require that less meat be consumed because you can produce -- you can't produce only meat in terms of a diet if you use agricultural land in different ways, in a more ecological way.

Q- So how do you -- I mean, if you're going to require less meat to be used, then ...

A- Well, in fact that's happening.

Q- And, as I understand it, people with that view of society look at things like unemployment as a public health issue?

A- Yes. It has a public health consequence.

Q- Yes.

A- In fact, the whole point about healthy public policy, which is one of the concepts that I helped to develop, is that most of the major determinants of health lie beyond the health care sector and that our objective must be to try and encourage the creation of public policies that are health supportive. And that would include unemployment.

Q- So I want to come back to your report now. Would you just look at page forty (40), your conclusion.

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THE COURT:

Have you given a number for this?

Me CHERNIAK:

Oh, I'm sorry, sir, if I haven't. Yes, the last one, I thought, did have a number.

THE COURT:

Okay. Okay.

Me POTTER:

RJR-172.

THE COURT:

Okay. No, because I didn't see it on that. Page forty (40).

Me CHERNIAK:

Q- So, in the middle of the second paragraph under your conclusion, page forty (40), My Lord.

You say:

"One of the characteristics of public health, given that it is as much political as it is scientific..."

-- and we...

A- All right.

Q- ...we've already gone through the part of your report that is scientific and how much is political:

"...has been the need to compromise with powerful economic forces. Sometimes to the

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detriment of the public's health and a need to strike a delicate balance between the rights of the collective and the rights of the individual."

That's certainly the political part of the exercise, isn't it?

A- That's right.

Q- Yes. And then you give the view that because of this political aspect of the debate the banning of tobacco has to be viewed as rather a mild infringement of freedom. That's your view, is it?

A- That's right.

Q- Yes. That's a political view, isn't it?

A- Yes, I suppose so.

Q- Yes. And then...

A- It's a view of the politics of the matter.

Q- And then you see this as a part of an ongoing process whereby social values, as you say in the next paragraph:

"Social values will change and the freedom of corporations to produce and sell this addictive and hazardous product will likely face even more stringent limitations."

In other words, let's do this gradually?

A- No, what I'm saying there is that, in my opinion, as social values change, the freedom will likely -- the

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freedom of those corporations will likely face even more stringent limitations. In other words, I am anticipating that that will happen. It is my opinion that that will happen.

Q- Well, because -- because we have to do this incrementally. We get one ban now, because it will allow us to do other bans later?

A- Because that has been the nature, in fact, of the whole approach to the tobacco issue over the past few years. It's been an incremental process as social values change.

Q- And you...

A- For that very reason, we've been able to introduce by-laws that regulate, for example, smoking in the work place that would have been unthinkable ten (10) years ago. Social values have changed, therefore there are more restrictions if you go back and look at the freedom that tobacco companies had to advertise thirty (30) or forty (40) years ago, compared to what they face now.

Q- And therefore, you view the tobacco products -- tobacco advertising, the Control Act, as another step in the process of changing the social climate?

A- Yes.

Q- Making it easier for the next step?

A- That's right.

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Q- That's your point. That's exactly what you say here.

A- Exactly.

Q- Then you say, because it's a part of the strategy, just paraphrasing your next paragraph, it's part of the strategy to reduce this modern plague. One of the multi-faceted strategies to reduce this modern plague.

A- Yes.

Q- Is it the advertising that's the modern plague or the use of tobacco products that's the modern plague?

A- The use of tobacco products.

Q- I see.

A- And the death and disease that -- what we're trying to reduce is the death and disease that results.

Q- And you go on to say that the elimination of tobacco advertising is an important component of it?

A- Yes.

Q- In part because it may reduce the inducement to smoke, and we've already dealt with your qualifications to say that, and will likely reduce overall consumption, and we've dealt with your qualifications to give that evidence, and in part because of the important message such a ban symbolizes, that's the political aspect of it, isn't it?

A- That's right.

Q- Yes.

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A- And, well, the social and political aspect.

Q- So, really, what you're saying is, there, that it's not all that important to you whether this ban works or not, because you don't know whether it will work, you only know what you've read, what's important to you is the social and political message that the act sends? Isn't that so?

A- What's important is both. I believe from what I've read that it will likely help but I think that it's part is as part of a comprehensive strategy to reduce tobacco use.

Q- But it wouldn't matter to you whether it worked or not. If the evidence was it didn't work, it would still be important because it would send the message out. Isn't that what you're saying?

A- Yes, I think that's part of it.

Q- Sure. That's what I thought. Thank you. Those are my questions.

Me POTTER:

My Lord, on qualifications, I only have two (2) or three (3) questions.

CROSS-EXAMINATION BY SIMON V. POTTER

on behalf of Petitioner, Imperial Tobacco Ltd.

Q- I have an easy one, first of all, Dr. Hancock. You're

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not a lawyer, are you?

A- No, I'm not.

Q- And have no legal training?

A- No.

Q- And you have had no professional training or experience in questions of legal history?

A- No.

Q- No. And you've never conducted an opinion poll survey?

A- No.

Q- And I take it you're not an expert in questions of confidence limits and opinion polling? You've heard pollsters say: reliable within ninety-five (95) -- ninety...

A- Yes.

Q- Are you an expert in all that?

A- I'm not an expert. I've had some training in confidence limits.

Q- But you're not an expert in it?

A- No.

Q- No. And you're not a psychiatrist?

A- No.

Q- And you're not a practicing psychologist?

A- No.

Q- No. And on the question of advertising, I take it you're not an expert in the influence of advertising on

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brand performance?

A- No.

Q- Nor are you an expert in the influence of advertising on overall sales, whether it's a big influence or a small one?

A- No.

Q- And you're not an expert on the influence of advertising in the difference in influence, depending on whether we're in a declining or an increasing marketplace?

A- No.

Q- No. And at page thirty-eight (38) of your report, you refer to statistics regarding the incidence of smoking. It's in that first full paragraph on page thirty-eight (38).

A- Right.

Q- And you refer to a direction paper, nineteen eighty-eight (1988).

A- Correct.

Q- Is this the direction paper you're talking about? Is it something that looks something like this?

A- Yes.

Q- Yes, that's Exhibit AG-101A, My Lord.

THE COURT:

AG-101?

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Me POTTER:

A.

Q- And are you an expert on that kind of business, calculating the incidence of smoking? How many people in different age groups are smoking at any given time, how many have tried to quit, what the trends are, what it looks like for different age groups or sex groups? Are you an expert in that, or have you simply accepted what is in that report?

A- No, I've certainly accepted what's in that report in terms of those statistics. Certainly the one thing I've been involved in designing, community health surveys in Toronto that have addressed that issue, and as part of the questions they've asked questions about smoking and smoking prevalence and so on, and certainly have looked, over the years, at data on smoking and health.

Q- What I'm asking you: are you an expert in the collection and study and interpretation of those statistics?

A- I wouldn't say I was an expert. I'd say I'm quite familiar with it.

Q- Right. As I might say I am today, after this case.

When did you get that direction paper? Did you -- was it part of your library or did someone send it to you?

A- I think I probably got it when it was first produced. I

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would have been on the mailing list, I imagine.

Q- Mailing list of that? And the New Zealand Toxic Substances Board, were you on the mailing list for that?

A- No, I was sent that.

Q- Who sent that to you?

A- Mr. Collishaw.

Q- Mr. Collishaw sent that to you.

Now, you know that article about the women, killing the women? That's RJR-169.

A- Yes.

Q- Do I take it, Doctor, that your opinion would also be that advertising aimed at men is a campaign to kill and maim men?

A- Yes, I don't think, in that sense, that there's a discrimination. I think that because fewer women smoke and because that has been a deliberate target, but yes.

Q- Yes. And do I take it that it would also be your opinion, Doctor, that independently of advertising, the marketing of the product itself is a deliberate campaign to kill and maim?

A- Yes, I think that given the knowledge that we have about what tobacco does and how -- and the health effects it has when used as intended, to continue to market it and promote it...

Q- And it would also be your...

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A- ...in the defiance of that evidence, if you like.

Q- In fact, Doctor, would it be your opinion that the simple offering of sale or giving of such a cigarette would be a deliberate campaign to kill and maim?

A- In a sense. I don't think that there's a deliberate campaign there, because I don't think that necessarily the people who are selling it are in a position to know the facts in the way that the tobacco industry is.

Q- Oh, I see, you're making a distinction between retail and wholesale sales?

A- I -- yes.

Q- What about the simple wholesale sale of tobacco products. In your opinion, is that a deliberate campaign to kill and maim?

A- Yes.

Q- Yes. Now, you've described yourself as a health futurist, Doctor?

A- That's right.

Q- I admit that I've never heard of one until reading your report.

First of all, are you surprised that I've never heard of one? It's an unusual term, isn't it?

A- It's a fairly unusual term, yes.

Q- Are there very many of these animals in Canada?

A- Not many. It's quite a small group.

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Q- Yes. Well, can you name some?

A- Yes, well, there's an institute of the -- what's it called, the Institute of Health Institutions for the Future, which was set up by a number of health organizations, including the Canadian Hospital Association, who were the prime movers behind it, for example.

Q- No, can you name individuals in Canada who are recognized health futurists?

A- Yes, some of my colleagues in Paradigm Health, I would say, are recognized health futurists. Suzanne Jackson, Neville Chenoy.

Q- Would those be the major health futurists in Canada?

A- I guess so at this point. I think, as I say, also the institute -- I've mentioned the institute already. I mean those are really the only organizations that have made a particular effort to look at the future of health.

Q- And Health Paradigm, isn't that something you set up?

A- Paradigm Health, it's a group that I was part of setting up, yes.

Q- M'hm. And in the United States, can you name recognized health futurists?

A- Yes, Rick Carlson, Clem Vezold, Peter Goldschmidt, Jerry, I think his first name is, Goldsmith. Those are

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some of the people. Len Duhl, I think would describe himself as a health futurist in part. Clem Vezold, and for that matter, his colleague, Jonathan Peck.

Q- Now, in your c.v., I'm looking at your list of consultancies, Doctor. It's on the first page of your c.v.

A- M'hm.

Q- First of all, am I correct in thinking that most of what you do now is consulting?

A- Yes.

Q- And that's been so for the past four (4) or five (5) years?

A- No, the past three and a half (3½) years.

Q- The past three and a half (3½) years.

And the first item in consulting: consultant and expert witness: Tobacco Products Control Bureau, Health and Welfare Canada.

Is that this case?

A- That's right.

Q- You haven't been an expert witness in any other case?

A- No.

Q- No. So if you are accepted as an expert witness in this case, that will be correct; is that so?

A- Yes.

Q- Thank you.

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THE COURT:

What do you mean?

Me POTTER:

If he is accepted as an expert witness, his c.v. will be correct.

THE COURT:

Oh, okay. Expert witness.

RE-EXAMINATION BY Me PAUL EVRAIRE

on behalf of Respondent

Q- Doctor, is the practice of public health a precise practice?

A- No, not at all.

Q- Why is that?

A- Well, because it's a combination to go back to that point again. It's a combination of science, art and politics, if you like. It's what is achievable given what we know and what we think we can achieve today. And it changes all the time.

Q- Well, as a public health practitioner, do you make recommendations to legislative bodies?

A- Yes.

Q- And in making those recommendations, how do you determine what is feasible in terms of socially feasible in making those recommendations?

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A- Well, it's a combination of -- to some extent, having a sense of public opinion from opinion polls and sometimes, for example, we -- well, maybe an example would be a good one, in fact.

Q- M'hm.

A- That when we were proposing the work place smoking by-law in Toronto, part of what we did was to conduct opinion polls and to review the literature on the extent to which that sort of by-law would be acceptable. And then, of course, we looked at the precedent in San Francisco. So that when we go and talk to legislators, we're able to say: this is what the opinion polls tell us is acceptable, this is the experience in other jurisdictions, this is what we think will fly.

Q- And do you rely on studies that other health practitioners may in fact undertake?

A- Yes.

Q- Now, do you need proof of success of a particular measure before recommending it?

A- No.

Q- Why not?

A- Because you often can't tell for sure that it will work until you actually try it, and if we required -- well, you can't have proof of success until you've actually tried it and seen what happens.

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Q- Well, to skeptics you may say: well, you shouldn't try it unless there's some kind of study or some kind of analysis to see that it might succeed. You shouldn't try it. What do you say to those skeptics?

A- Sometimes it depends where you are in the stage of the public health process. For example, when we came to implement the non-smoking by-law in Toronto, we had some belief that it might work because we'd seen it work in San Francisco. But clearly, when they implemented that by-law in San Francisco, they had no way of knowing whether it would work or not, because no one else had ever done that before.

Q- Thank you, My Lord. Those are my questions in re-examination and on qualifications.

My friends have attempted, My Lord, in their cross-examination, to suggest that Dr. Hancock should not testify...

THE COURT:

You don't even know if there's an objection yet.

Me EVRAIRE:

All right. Maybe there isn't.

THE COURT:

Maybe we should wait.

Me EVRAIRE:

Maybe I should wait. All right.

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THE COURT:

Maybe.

Me EVRAIRE:

Well, I will just conclude by saying it's my submission that Dr. Hancock is qualified to testify in those areas of his report.

Me CHERNIAK:

My Lord, I'd like to argue against the admission of any evidence by Dr. Hancock and his report. It's going to take me a little while to do it.

My submission is that it would be inappropriate, in case it is determined that Dr. Hancock may give evidence on all or some parts of his report, it's inappropriate that Dr. Hancock be here to hear this argument because it might tend to indicate certain areas of the cross-examination that he might be subject to before he's been examined in chief.

So I would ask that Your Lordship excuse Dr. Hancock and ask him to wait outside until this argument's done.

Me EVRAIRE:

Well, My Lord, indeed I've never heard of that. In fact, I can think of one Federal Court decision called Duquet versus The Public Service Commission in which Justice Collier of the Federal Court held the view that

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an expert can attend at all times throughout the trial of the matter, especially given that an expert needs to form opinions and to hear indeed...

THE COURT:

Yes, but that's argument. That's not evidence.

Me EVRAIRE:

Well, I appreciate that. It's my submission that it would not -- my friend has had the report for some time, my friend has already cross-examined the witness as to many areas of the report. I take no strong view of it. I just say that I think it's an unnecessary request to the Court.

14/0063

THE COURT:

Well, we'll ask you to wait outside, Dr. Hancock, until we hear the argument on your qualification as an expert.

(WITNESS LEAVES THE COURTROOM)

Me CHERNIAK:

My Lord, there are a number of reasons why this man's report and expertise should not be admitted in this case. One is a relatively narrow one, to the extent that he offers the opinions that he has on, I think it's page thirty-six (36) of his report, dealing with the effect of -- of the reasons why this Act should be --

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should be found to be in the public interest, item six point one (6.1) going from page thirty-six (36) to page thirty-eight (38).

My submission is that the man has absolutely no expertise whatever to offer the opinions that he has offered in -- on those pages. He doesn't purport to have any experience, training, background in the effect of advertising on consumption or the extent to which a ban on advertising will affect consumption of any segment of the population. And indeed, he didn't even know of the evidence that we've had in this case as to date on that issue from Dr. Lefcoe, whose evidence, Your Lordship will remember, was that he had done extensive studies in that regard and among the various factors that he thought influenced young people to smoke, advertising wasn't one of them. So this man simply has no qualifications whatever to offer opinions with respect to the impact of advertising or the lack of advertising on consumption.

The balance of the report, both in that section and generally, is not admissible for a number of reasons. In the first place, this man really isn't an expert on the social and political context of this Act any more than any other member of the public. He is giving an opinion as to whether -- whether this Act is socially

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and politically acceptable and that's simply not the subject matter of expert evidence. The subject matter that this Court has to deal with, based on admissible evidence from persons who have otherwise admissible testimony, based on their personal knowledge or their expert evidence, but if this was simply a question of finding experts who say: "In my view, it's socially and politically acceptable", and others who say: "In my view, it's not socially and politically acceptable", I don't suppose that we need Your Lordship -- that's what this case is all about -- to determine.

I suppose as good an example as anything is one of the major arguments that this man uses in his report, in which he justifies the social and political acceptability of this Act because it was passed. That's one of the main bootstraps that he uses to argue that the Act is therefore justified: it passed. And in fact, it's quite clear from both what he said and what he has written that this man, with respect to the social and the political aspects of the Act, as opposed to the effectiveness of the Act to do what it is said to do, this man is not an expert at all. He is an advocate. He is really in no different a position than if he had applied to intervene in this case on behalf of one of the many organizations that he either represents or

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consults for.

It is simply political opinion in respect of which no expertise is needed. You simply have to be, want to be for one reason or another an advocate of one cause or another. It's simply a -- a political position that he has chosen to take because of his particular beliefs about the dimensions of the problem which is...

THE COURT:

Well, the fact that he's an advocate doesn't change or have an effect on his expertise. That's not the point. It goes to the weight of his testimony and not to the fact that he can or cannot testify himself.

Me CHERNIAK:

With great respect, My Lord, it goes to the admissibility of the evidence at all. It would be as if we called a lawyer to say that, in his view, the facts in this particular case demonstrate a clear negligence. This man is saying in his view the facts that other people have put forward demonstrate the social and the political necessity of -- and acceptability of this legislation. Simply it wouldn't be competent for a man to say: "I've reviewed the evidence. It looks like negligence to me."

You can have an engineer say: "This is what..."

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THE COURT:

Yes, that's a different argument, but the fact that he might advocate certain positions doesn't go to the admissibility of his report but to the weight of it.

Me CHERNIAK:

Well, but one first has to see does he have -- does he have qualifications...

THE COURT:

Okay, that's a totally...

Me CHERNIAK:

... in which to...

THE COURT:

... different ball game.

Me CHERNIAK:

... in which to give his particular perspective and is it an issue upon which evidence can be received in the first place? Let me just deal with that. The Supreme Court of Canada has made it clear in the Béland case and the Abbey case what the limits of expert evidence is and I referred Your Lordship to these cases when we dealt with Mr. Burns in the...

THE COURT:

By the way, I've just read, at the morning break, I've read again the decision of Abbey. So if you want to quote some...

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Me CHERNIAK:

All right.

THE COURT:

... it's fresh in my mind.

Me CHERNIAK:

Perhaps I will quote from Abbey then, because that's the -- does His Lordship have a copy...

THE COURT:

Premonition.

Me BAKER:

You anticipated it too.

Me CHERNIAK:

Abbey is -- that's the leading case on the issue and the Béland case follows the Abbey case. Here's a copy of the Abbey case. Does Your Lordship have a copy?

THE COURT:

It's in the office, in my office.

Me CHERNIAK:

I'll just hand this up to Your Lordship. I think we will find this at page forty-two (42) of the -- of the judgement, the passage that is most often quoted.

THE COURT:

Turner case, yes.

Me CHERNIAK:

"Witnesses testify as to facts. The judge or

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jury draws inferences from facts but the law, in the law of evidence, opinion means any inference from observed fact, and the law on the subject derives from the general rule that witnesses must speak only to that which was directly observed by them. Where it's possible to separate fact from inference, the witness may only testify as to fact. It is not always possible, however, and the law makes allowance for these borderline cases by permitting witnesses to state their opinion with regard to matters not calling for a special knowledge whenever it would be virtually impossible for them to separate their inferences from the facts on which those inferences are based.

With respect to matters calling for special knowledge ..."

-- now that deals with opinions by lay witnesses who are observing facts and who might have some opinion flowing from them, that's not the issue here --

"With respect to matters calling for special knowledge, an expert in the field may draw inferences and state his opinion. An expert's function is precisely this, to provide the

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jury with a ready made inference to which the judge and jury, due to the technical nature of the facts, are unable to formulate.

An expert's opinion is admissible to furnish the Court with scientific information which is likely to be outside the experience and knowledge of the judge or jury. If on the proven facts the judge or jury can form their own conclusions without help, then the opinion of the expert is unnecessary."

Now, with respect, here it is clear that expert evidence would be and indeed has been and will continue to be admissible on the issue as to whether, on the first two (2) issues, that the man mentions in that section of his report: does advertising influence the decision to smoke and will a ban on advertising affect the consumption of tobacco, if that was the issue upon which this man was giving evidence and he had the expertise to do so, the admissibility could not be challenged.

14/009420 This man admittedly has no expertise to assist Your Lordship on those issues and there have been and will be other witnesses who are directing their mind and, based on their expertise, to that very issue. This man has no such expertise. He has said he simply accepts the views of others and seeks to draw an inference from those

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facts that he accepts from others, but the point is that what he seeks to advise Your Lordship are based on those facts that he accepts from others, or those opinions that he accepts from others, is the social and political acceptability, in other words the Section 1 test.

I say to Your Lordship that is a question which falls within the knowledge and experience of the trier of fact. You don't need expert evidence to assist you in determining the Section 1 test and it is inadmissible for anyone to come and say to you: "In my view, this does or does not satisfy that test." It's not really a question of the ultimate issue, it's a question of simply being outside the scope of expert evidence.

THE COURT:

Aren't you hungry?

Me BAKER:

He's tough. He never gets hungry.

Me CHERNIAK:

I probably am, My Lord, although I had to have breakfast with my friend Mr. Potter this morning, so I was about an hour and a half (1½) later than I usually am.

Me POTTER:

I might say I'm already hungry, My Lord.

THE COURT:

Good, Mr. Potter. So we'll resume at two fifteen

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(14:15)? Is that suitable?

Me EVRAIRE:

Sure.

LUNCH ADJOURNMENT

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In the year of Our Lord nineteen hundred and ninety (1990), on this nineteenth (19th) day of the month of March, PERSONALLY CAME AND APPEARED:

Me CHERNIAK:

Earl Cherniak for RJR-Macdonald.

Me POTTER:

For Imperial, Simon Potter.

Me EVRAIRE:

For the Attorney General, Roger Baker, Claude Joyal and Paul Evraire.

THE COURT:

Maître Cherniak?

Me CHERNIAK:

My Lord, if I can hand you up the Béland case. I referred to this in the last argument we had on this issue. If you'd turn to page four fifteen (415).

THE COURT:

Béland?

Me CHERNIAK:

Page four fifteen (415). This was the case involving a number of evidentiary issues but all dealing with the admissibility of polygraph evidence. And at page four fifteen (415), Mr. Justice McIntyre, after referring to the passage from Abbey that I just quoted to you, added

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his own gloss to the proposition. First of all, quoting from Davey versus Magistrates of Edinburgh in which Lord Cooper said:

"Their duty ..."

-- meaning expert witnesses --

"...is to furnish the judge or jury with the necessary scientific criteria for testing the accuracy of their conclusions, so as to enable the judge or jury to form their own independent judgement by the application of these criteria to the facts proved in evidence. The function of the expert witness, Mr. Justice McIntyre goes on to say, is to provide for the jury or other trier of fact an expert's opinion as to the significance of or the inference which may be drawn from proved facts in the field in which the expert witness possesses special knowledge and experience going beyond the trier of fact. The expert witness is permitted to give such opinion for the assistance of the jury. Where the question is one which falls within the knowledge and experience of the triers of fact, there is no need for expert evidence and opinion will not be received."

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And I say, My Lord, that there's two (2) propositions that apply to this case that comes out of those passages. One, it's a given that the expert witness must have the special knowledge and experience going beyond the trier of fact and with respect to the implications of the -- of what factors go to tobacco use and the effect of an advertising ban, this man has no such qualifications and secondly, to the extent that he purports to give the social and political implications of it, that is something about which any member of the public can or may have an opinion and, of course, which Your Lordship must decide in this case, in the context of the Charter of Rights.

16/0147 If I can refer Your Lordship -- I'm reluctant to refer Your Lordship to your own judgments but there is a couple of passages that are -- that are important.

THE COURT:

Don't be afraid. I think it's a very good one.

Me CHERNIAK:

The one that I want to refer Your -- Mr. Potter told me that I should be diffident about doing so, My Lord -- is...

Me POTTER:

Not that I think it's a bad judgement, My Lord.

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THE COURT:

It took you some time.

Me CHERNIAK:

... is the passage that is pertinent to this argument in the judgement that Your Lordship rendered when the Canadian Cancer Society made an application to intervene and I'm referring to the Dominion Law Report, report of the case, and I have some copies here for convenience, at page five seventy-one (571) where Your Lordship said this, about the middle of the page:

> "This Court must refuse to allow itself to be influenced by public opinion or political considerations that may be relevant to a given decision. But the Court is not so naive as to believe that a judicial decision might not have political consequences, certainly, but it is important not to confuse cause and effect. The Courts cannot be bound, except by the law that they apply in their own decisions rendered according to the law. They must not be concerned with the knowledge whether their decisions are popular or not, whether they are accepted or not, glorified or vilified by the

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> population or by certain sectors of the population or by the executive or administrative powers of the state. The only concern of the Court should be to do justice according to law. If a decision should entail political consequences for politicians to adopt or enact legislation, they will take them into account.
>
> To transform the serenity of the judicial forum into an arena for political or social partisanship must be avoided. It is the opinion of this Court that the importation of a concert of political or social legitimacy in Canadian constitutional law cannot be but injurious to the primacy of the rule of law as recognized in the preamble to the Charter."

And I say to Your Lordship that every single word of this report violates that dictum that Your Lordship laid down in this case.

THE COURT:

Wasn't it in another context though?

Me CHERNIAK:

Well, it was in another context, My Lord, but it's within the very issue -- within the same pleading

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framework that we're dealing with here. There you said a special interest group should not be allowed to take part in the proceedings.

Here we have what is, in effect, a one-man special interest group. This man has an agenda. Read his writings. He has an agenda. Included in that agenda, and the agenda is his own words, included in the agenda of health professionals like him is, among other things, the complete banning of tobacco and alcohol. He said that agenda goes back as far as eighteen seventy-five (1875) and is still in the agenda. And it's the agenda of the public health professional.

If you read the other -- one of the other articles I've put in, it's part of the mission that public health professionals have. He says in -- with respect to the Health Advocacy Unit of Toronto that one of the things that they are advocating is a -- I can't remember if it was smoke-free society or a non-smoking society in twenty (20) years. This man, as I say, he is -- he's not the Canadian Cancer Society, he is a one-man political advocacy group. He makes no bones about it. The burden of his report is that there is this incremental, since it's politically impossible at the moment to totally ban tobacco, what we have to do is create the social climate in which that will be

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possible, by doing it incrementally. It doesn't matter to him, it really makes no difference whether it will work to reduce the tobacco consumption or not, what's important is that it will send a message -- again, his words -- to society that smoking is a socially unacceptable thing to do.

That is an interest group. That is a consequence. That is a political and social statement as to the political work of this legislation.

The point is that politically if, say, this decision went against the government, the government has got a political out. The Charter leaves a political out. They can override any judicial decision that affects the legislation. That's the political out. And what these arguments in effect say is: it doesn't matter whether it works or not, it doesn't matter whether it's a minimal interference or not, politically the override section ought to be used. Well, that's not an issue that is relevant in this Court.

If I can refer Your Lordship to the passage that you cited from the Motor Vehicle reference case, when you gave the October twenty-third (23rd) judgment of this Court.

THE COURT:

No, I mean which dealt with what?

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Me CHERNIAK:

Which dealt with the way in which the Court must approach the Charter...

THE COURT:

On the book.

Me POTTER:

It's the Warner book, My Lord.

Me CHERNIAK:

Oh, sorry. Yes, it's the Warner case. The October twenty-third (23rd) case. And this is at page sixteen (16) of your decision.

"Mr. Justice Lamer in the Motor Vehicle Reference case said this:

'In either case, be it before or after the Charter, have the Courts been unable to decide upon the appropriateness of policies underlying legislative enactments. In both instances, however, the Courts are empowered, indeed required, to measure the content of legislation against the guarantees of the constitution.'"

So what Mr. Justice Lamer was saying was: the appropriateness of the policies underlying these enactments are not for the Court, but that's precisely what this man's report goes to: the policies underlying

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the appropriateness of the legislative enactment.

What the Courts are to deal with under Section 1 is not the policies at all, but rather to measure the content of the legislation against the guarantees of the constitution. This man's report doesn't go to that, nor would he have any expertise to assist you in measuring the guarantees -- the content of the legislation against the guarantees of the constitution. That's not for him.

Mr. Justice Lamer quotes what Mr. Justice Dickson says in the Amex Potash case. Mr. Justice Dickson as he was in nineteen seventy-seven (1977). And Your Lordship referred to this as well in your judgment:

> "The Courts will not question the wisdom of enactments, but it is the high duty of this Court to ensure that the legislatures do not transgress the limits of their constitutional mandate and engage in the illegal exercise of power."

Now, when Chief Justice -- Mr. Justice Dickson said that, this was nineteen seventy-seven (1977), of course in the context of the division of powers, because that was the only constitutional issue at that time, Mr. Justice Lamer brought that principle into -- as being applicable to the powers of the Court with respect to the Charter of Rights as well, because of course the

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Motor Vehicle reference case was a Charter case.

And Your Lordship went on to quote to the same effect the case of the Public Service Alliance versus Manitoba, which is a nineteen eighty-nine (1989) decision in the Supreme Court of Canada where Chief Justice Dickson said:

> "In my opinion the Courts must exercise considerable caution when confronted with difficult questions of economic policy."

And I suppose we could substitute social policy.

> "It is not our judicial role to assess the effectiveness or wisdom of various government strategies for solving pressing economic problems. The role of the judiciary in such situation lies primarily in ensuring that the selective legislative strategy is fairly implemented with as little interference as is reasonably possible with the rights and freedoms guaranteed by the Charter."

That's the issue before you. This evidence is directed to what Chief Justice Dickson was talking about, the assessment of the effectiveness or wisdom of the various government strategies. That is an irrelevant consideration in this Court. And since it's irrelevant, evidence about it can't be relevant. Now, if I can just

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refer Your Lordship to certain other pages in your decision on the -- on the Warner book. I won't read them to you but if Your Lordship looks at page eighteen (18) where you deal with the principles about a justification under Section 1 -- I'm sorry, I do have a copy of this judgment here for you.

THE COURT:

Is this...

Me POTTER:

I'll put more copies behind you for your friends.

Me CHERNIAK:

I keep one in my back pocket to consult it all the time, My Lord. At page eighteen (18), you deal with your ruling about the principles involving a -- the justification under Section 1 and then at page nineteen (19), you -- about halfway down the page, you deal with admissibility and point out that whether its legislative facts or adjudicative facts it is of no value in determining admissibility since the material would still have to be measured in terms of its relevancy to the -- with the issue, its reliability and its general admissibility.

Now, what I say here is, first of all, this evidence has no relevance to the Section 1 issue at all for the reasons I've outlined. It's unreliable and I'm

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going to come to the question of bias in a moment, in the last matter that I will argue, and its general admissibility under the Civil rules of evidence, I have largely already dealt with. And then, if we turn to page thirty-two (32) of your reasons. After reviewing many authorities, you say this:

> "In the Court's opinion, the Canadian legal system, in particular the Canadian law of evidence as developed over the years by the Courts, is perfectly apt to solve the evidentiary issues raised in constitutional cases of first instance by resorting to the normal rules of evidence and by refining them to the case if need be. The basic rules of evidence, relevancy, hearsay, best evidence and judicial notice are the key to solving the problems of evidence in constitutional case at first instance."

And then if you would turn to page forty-four (44), where you made the decision in the actual case. You quote with approval from Mr. Manning's article on proof of facts in constitutional cases, where Mr. Manning said this -- this is at the bottom of page forty-four (44).

> "We must also guard against the tendency to rely too much on experts invading the ultimate

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issue area. We must guard against an expression of general belief which is really directed to an opinion as to how the case should be decided. The Court must avoid shifting the responsibility to expert witnesses to decide the case. It is for the Court to evaluate the facts in the light of acceptable and applicable rules of law and not for the expert to ultimately determine the case."

Now, in my submission, the report and evidence -- proposed evidence of this witness fails that test as well. Now...

THE COURT:

By the way, is this one on appeal because I lost track of which one?

Me BAKER:

No -- no, My Lord...

Me CHERNIAK:

This case was never appealed, My Lord. There was no appeal.

Me EVRAIRE:

We gave you one.

THE COURT:

Rightly put.

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Me CHERNIAK:

At the moment, My Lord, this represents the latest and unappealed version of the law of Quebec, as I understand it. The -- if Your Lordship looks at the -- at the conclusion that I cross-examined the witness on this morning at page forty (40), you'll see that it's really no more than a summary of what the other thirty-nine (39) pages of the report have outlined and it's either inadmissible because it goes beyond the man's expertise or it seems -- or it goes beyond the relevance in this case by attempting to instruct Your Lordship on the social and legislative and political policy behind the legislation in the first place, an irrelevant consideration here, and you'll see that the witness clearly in the middle paragraph under a conclusion -- at least, under the second paragraph under a conclusion, makes it clear there and on page forty-one (41) that the issue for him isn't really whether the elimination of tobacco advertising will reduce the overall consumption somewhat or not, as it is the message that the ban symbolizes. Those are the witness' words on page forty-nine (49).

"A ban on advertising will further strengthen the message to society as a whole, and to those considering starting smoking, that

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smoking is now socially unacceptable."

Those simply are not constitutional considerations in the sense that Mr. Justice Lamer used them and Your Lordship has used them.

The final point that I wish to make, sir, is that, apart from anything else, this witness' declared bias against tobacco advertising generally and tobacco companies in particular has gone so far as to negate any possible usefulness that he can have in this case. A man that could write that the tobacco companies by their advertising are involved in a deliberate campaign -- not the effect of which is, but by a deliberate campaign to destroy or kill -- I can't remember the words -- women and men in this country, has demonstrated a bias, a vindictiveness that goes so far as to negate any possible fairness or impartiality that it seems to me must be the...

THE COURT:

That -- that goes to the weight of evidence, not the admissibility.

Me CHERNIAK:

Well, surely, sir, when a man comes in and demonstrates on the very issue -- the issue here is tobacco companies and tobacco advertising. The very issue, and when he demonstrates that kind of bias, surely there comes a

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point at which you have to say look, this man can't help me. An expert witness, by definition, is supposed -- at least as I always understood, it is to be giving dispassionate, impartial learned, scientific evidence to assist the Court.

Now, someone that comes in the Court with the predetermined bias that this man clearly has and combined with -- combined with the writing about his agenda to eliminate smoking with his agenda -- when he talks about his mission with the political agenda in the article that describes the five (5) different political agendas to so redirect society that less land will be devoted to -- to the kind of crops that will produce alcohol and tobacco and meat, that his written articles that indicate that the public health movement, public health -- persons involved in public health must, in effect, take up the political fight against things like tobacco. When, with that background and the man has a declared bias on the very issue in this case, that of tobacco advertising seems to me that the Rubicon has been crossed and his bias is so demonstrable that his evidence is so valueless that it shouldn't be received at all. Those are my submissions.

THE COURT:

Mr. Potter, do you have something to say?

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Me POTTER:

Only to say, My Lord, that if you do come to the conclusion that it's only a matter of weight, that we should have the right during the gentleman's testimony, if ever he gets to that point, to hold him to the limits of what expertise he does have, that he should not be allowed to stray into areas where he has no expertise and to -- to join my friend, Mr. Cherniak, it seems to me his expertise is that he is an expert on the future and I wonder just to what extent that can be of any help to you.

THE COURT:

Maître Evraire?

Me EVRAIRE:

Starting, My Lord, with my friend's issue on bias, indeed it is a question of not admissibility but a question of weight to be given to the evidence. I should have thought my friend's comments would have been more appropriate in a jury trial. One assumes that a judge sitting alone is able to distinguish between biases or inherent values of certain witnesses and distinguish those from perhaps the facts and the legal questions that have to be determined. And as I say, those comment are more appropriate if one is seeking to knock out of the box a witness that may seek to

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influence a more influenceable jury or member of a jury.

.9/0053 In any event, as you heard the witness indicate this morning, it is not unusual for public health -- let me call them specialists for lack of another word -- to have a position on health issues. Dr. Hancock has indicated that he has a position on tobacco, as indeed he does on many other diseases and other areas of health. That's inherent in his position. To then try to catapult that into a bias such that my friend would have him not testify on that basis alone, I say is leaping much too far and I say no more about that.

On the question of ultimate issue, which my friend tended to approach that but then backed away, it's as if there were a precipice he was afraid to approach. It's my submission that Dr. Hancock has not touched on the ultimate issue. Your Lordship, I have one of your judgments as well and it's a little bit different this time. It's the judgement on Dr. Burns where he spoke of what is the issue in this case.

THE COURT:

That's the man from California?

Me EVRAIRE:

Yes, it is. Your Lordship is speaking to the issues in this litigation at page six (6) of your judgement.

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THE COURT:

This one is in appeal though.

Me EVRAIRE:

It is, yes.

THE COURT:

Not that I -- not nothing.

Me EVRAIRE:

Not that anything turns on that, but on this point I don't think there's any disagreement and indeed this is not an issue that's being raised by us, but at the bottom of the first full paragraph on page six (6), you say:

"The issue is not ..."

-- and in this case, of course, we were dealing with the Surgeon General's reports --

"The issue is not whether or not the reports of the Surgeon General are reliable and credible, but whether the use of tobacco is detrimental to health and, as the case may be, the extent to which it is, and Dr. Burns is now produced to advance his personal and professional opinion in that regard."

It's my submission that there may yet be another grander issue on the legal facts in this case, and that's whether the Tobacco Products Control Act,

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a) offends the freedom of expression under the Charter and if it does, if you should so find, whether Section 1 considerations save the legislation notwithstanding. My friend, I think, attempted somehow to suggest that Dr. Hancock's testimony touched on those very issues under the Charter. It's my submission there is no such thing in the report.

In fact, my friend sought valiantly to minimize the area in which Dr. Hancock brings forth an expertise to the Court. And I use the word "expertise" advisedly. Dr. Hancock just doesn't come here to spout an opinion as to what's socially and politically acceptable here.

THE COURT:

Quite frankly, that's what I'd like you to address. He's an expert in what? I'm not sure yet.

Me EVRAIRE:

Very good. He is an expert...

THE COURT:

Quite frankly.

Me EVRAIRE:

We suggest he is an expert and should be so found in the area of public health, the history of public health, the way public health has been sought to deal with disease in society, and he explains that by setting out in his report the principles which are important for a public

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health professional to consider.

You'll recall his testimony of this morning is that he is in a position, as a public health professional, to give advice to legislators, not in his experience to the parliament of Canada but in his experience, for example, to municipal officials, provincial officials, officials in other countries. There is a problem. He, as a public health official, brings principles to bear in making recommendations to them.

For example, at the bottom of page twenty-nine (29), if I might refer you to his report...

THE COURT:

Twenty-nine (29)?

Me EVRAIRE:

Twenty-nine (29). Indeed, page twenty-eight (28) and twenty-nine (29). Twenty-eight (28) to start off with. Dr. Hancock says that, under the heading "Criteria for Public Health Action", if I may read quickly at the bottom, starting with the paragraph "The issue":

> "The issue of what are the criteria which trigger public health action have remained remarkably constant over time. In his review of the origins and development of public health, Chave notes that the sanitary idea of Chadwick and the 19th century public health

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movement consisted of 3 parts: a theory of causation, a remedy for the problem and a proposal for implementing the scheme."

He then goes on to quote Detels and Breslow and then sets out, at the top of page twenty-nine (29):

"Thus, public health action is based on 3 criteria, and I underscore the fact that these must be seen as a package:

a) the nature and severity of the problem;

b) the availability and effectiveness of a remedy and the political and social acceptability of that remedy."

And then he puts those three (3) into sub-components which are set out at page twenty-nine (29), concluding at the bottom of page twenty-nine (29) with these words:

"These and other criteria are weighed by public health professionals and their political masters in determining the appropriate course of action."

To suggest that he is not to testify in the area of what is socially and politically acceptable would really leave the public health professional in a fairyland of what are the problems, what's the remedy, but never to address the question of whether that remedy is acceptable, never to determine whether or not there is

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any real world to be addressed in suggesting remedies.

For example, if we look at prohibition, there was a problem, perhaps too much alcoholism. The remedy found at that particular time was to ban all alcohol consumption, but as it turned out it was socially, I would suggest, and politically unacceptable, it simply didn't wash with the American public.

That is the dimension that Dr. Hancock is adding to the nature, the scientific nature of the problem, the proposed remedy. It must be put in the context of reality and that is where the public health professional is able to give the Court the benefit of Dr. Hancock and others' experience in this domain, and so when my friend says: "These are areas on which anyone could come to the Court and express an opinion", I suggest that is not the case.

Dr. Hancock is able to bring to bear his experience with the City of Toronto, his own personal practice of medicine, his consultation with other countries indeed, in suggesting in the context of public health principles whether this remedy, namely the banning of tobacco advertising, is a socially and politically acceptable one in today's society. He doesn't come here as a demographer, he doesn't come here as a social scientist. He comes here as a public health professional who

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applies these principles on a regular basis.

THE COURT:

How is that going to help me in my decision, or why are you putting him forward?

Me EVRAIRE:

Well, it would help you in your decision in this way. Your Lordship, after hearing him and Dr. Turcotte, who you will hear, I hope, after Dr. Hancock, will be able to explain to you that public health -- public health professionals who are indeed doctors, as Dr. Turcotte also is, view this as a remedy which can work essentially. A public health professional cannot suggest a remedy if it's simply not going to take off, if it's simply not going to be effective, and they are able to bring to bear their experience with other examples.

Dr. Hancock's report is riddled with situations where indeed measures have been put into place. He speaks for example, at page... He speaks at page eleven (11) for example, by reference to the works of others in public health, of examples where public health in fact was in the vanguard of dealing with particular medical problems, health problems, and he gives, for example, at the bottom of page eleven (11), the following. He says:

"Public health reached its zenith between 1890

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and 1910 in what Winslow called it's "Golden Age." During that period ..."

-- he goes on --

"... the dramatic declines in mortality from infectious diseases resulted from the sanitary activities of the public health movement and were complemented by the discovery of specific microbial agents and the development of specific vaccine."

He goes on:

"In the 1930s, however, the first antibiotics became available and the clinical and therapeutic models slowly came to dominate the health scene. After the Second World War, the introduction of the National Health Service in Britain and a public health insurance and national medical insurance in Canada cemented in place a therapeutic model as the main instrument for improving the health of Canadians."

What he can bring to bear to the Court, how he can help Your Lordship, is to show past experiences where, not only was there a problem, but a remedy, but a determination of whether that remedy could realistically be implemented into society.

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Your Lordship is then able, after hearing Dr. Hancock and Dr. Turcotte, to say I've heard the opinions of two (2) public health professionals who are of the view that, given their experience, it is socially acceptable to, for example, ban advertising, because it might reduce inducements to consumption, in their professional medical opinion, while they do not feel that banning the product would do so.

These are people who have dealt with patients, who have treated patients, who bring that experience to bear in assessing the problem. As I say, we could bring political scientists and sociologists to explain from their perspective whether this legislation is a realistic approach to the problem. What they bring to you, My Lord, is the medical community's perspective on whether it is realistic to try this or not.

And that is where I disagree with my friend where he says: they bring no expertise to the Court. It's my submission that they do bring to you that focus. You've heard other medical practitioners, Dr. Robitaille and Ostiguy and so forth, who said essentially the same thing.

THE COURT:

Well, no, well, they were testifying to their field of expertise.

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Me EVRAIRE:

Indeed.

THE COURT:

Here you have someone whose field of expertise, as he says he is, is the field of opinion.

Me EVRAIRE:

Well...

THE COURT:

I mean, science, heart...

Me EVRAIRE:

And politics, if you will.

THE COURT:

And politics.

Me EVRAIRE:

Well, as I say, Dr. Hancock....

THE COURT:

Can you be an expert on -- well, maybe you can. I don't know.

Me EVRAIRE:

Well, it's my submission that you can. Let's take the example of the experience of Dr. Hancock. He was working in the Health Advocacy Unit where they identified a problem, came up with a remedy, let's say took tobacco bans through by-laws in the City of Toronto, and recommended those to the political masters,

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to those who pass legislation. As a result of that, one would think that the quality of air perhaps of non-smokers in the work place in Toronto would improve, the health would improve of people within those areas where the by-laws have certain effect. And it is only because of the role that the medical society, through the Dr. Hancocks, by pushing the politicians, if you will, were able to encourage the passing of such by-laws. I'm not saying they take all the credit, but that is a focus.

How strange would it have been for City Council in Toronto to pass such by-laws and somebody would say: well, did you ask any doctors if this makes any sense?

And really, My Lord, that's what Dr. Hancock is coming here to say to you. Does it make any sense from a medical point of view to attack the problem in this way?

It's my submission that given the experiences of public health over the past few centuries, Dr. Hancock is able to express to you the opinion, as he does in his report, that it does make sense. And why does it make sense? Well, my friends will say: well, he relies on the crop study or the opinion poll. He relies on certain data from Health and Welfare. That's really not worthwhile, because he's not a statistician, he's not a

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poll taker. But any expert is entitled to rely on the works of others. No expert is in a position to be knowledgeable in all areas. He himself said, in his own cross-examination this morning, that he took surveys.

It is simply a dimension that the medical community, I think, brings to bear to the Court which you can't see through any other witness.

Now, a fallback position, if I may be allowed. If Your Lordship is of the view that certain parts of Dr...

THE COURT:

I am of no view now. I'm just wondering.

Me EVRAIRE:

All right. Should you take the position that Dr. Hancock has overstepped his expertise in speaking of the social or political aspects, even bearing in mind that they are necessary, it's a marriage really, as he puts it at page twenty-nine (29). It's a marriage of all these elements. They cannot be broken up. You have to live in the real world. That's all he does in touching on social and political aspects.

But if Your Lordship should take the view that certain parts of that are not appropriate for him to testify about, it is my submission that the appropriate modus operandi should therefore be that certain parts of his report may not be received by you, but that the

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balance of his report, in areas that you are satisfied he has expertise in should be receivable in evidence, and that he should be allowed to expand on certain parts of his report, viva voce, through examination in chief.

Just one comment on my friend citing the Canadian Cancer Society judgment of Your Lordship's. I think your point is well taken. That is an entirely different context. An individual who has an opinion, well, indeed all experts who come to this Court have an opinion, but that was a situation where parties outside the litigation sought to come and, as you characterized it in your judgment, sought to influence by public opinion or other political considerations, the judgment of the Court.

That is not what's going on here. We have an expert who has deliberated on the issue of public health and who has sought, valiantly, I'd suggest, in his report, to expose the principles which come to bear from the public health perspective and has sought to make the Court the beneficiary of those.

Just one last point, and that's a comment by Dr. Hancock himself, at the bottom of page -- sorry, in the middle of page thirty-six (36), and paint Dr. Hancock, as my friend may try, as biased and simply having a strong dislike of the tobacco industry, where he refers

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in the middle of paragraph two (2) on page thirty-six (36) of the Tobacco Products Control Act, Dr. Hancock concludes:

"The Tobacco Products Control Act then must be evaluated..."

-- and I underline the following words:

"...in the context of public health principles and the global and national programs to control and reduce tobacco use."

And that is the other aspect of it. Dr. Hancock spoke today of the comprehensive approach to dealing with tobacco use and tobacco-related diseases. It is not in isolation, he says, I like this legislation, it will really hit the tobacco advertising on the head. It is as part of this exercise that he's saying essentially, it is inconsistent to try to deal with these diseases and, on the other hand, continue to promote the very product which, when used as intended, and you've heard that expression often enough, does indeed kill. And that, I submit, is the evidence that we have put forth on behalf of the Attorney General.

So it's my submission, My Lord, that the appropriate procedure from this point on should be for Your Lordship to consider him an expert in public health, to receive his evidence, and the weight to be

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attached to that is certainly a matter that you know is for you to determine when all of the evidence is in.

Another suggestion I would make, or submission, is that it might be appropriate for Your Lordship to weigh it in the context also of the evidence of Dr. Turcotte, who will be testifying later this week. It may be that if my friends are not in a position to show Dr. Turcotte having written articles that my friend has similarly put to Dr. Hancock this morning, you might be able to judge that matter in a more objective light than my friends have sought to paint Dr. Hancock. They've sought to paint him, indeed, as a zealot and one who is just all -- as all get out to kill the tobacco industry. It's my submission that we must remember what Dr. Hancock said. He is concerned -- his only advocacy is for public health. Those are my submissions.

THE COURT:

Yes.

Me CHERNIAK:

Any painting, My Lord, was done by Dr. Hancock, not by me. He painted -- he wrote his own articles, not me.

My friend does not seem to appreciate the distinction between what Dr. Hancock might be able to do in giving advice to the City of Toronto Council, Metropolitan Toronto Council or indeed the parliament of

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Canada, when it was considering the political wisdom of passing legislation or not. The Dr. Hancocks of this world will no doubt always have something to say about the -- about the state of public opinion and the social and political context whether -- whether it's right for this kind of legislation or not. But having said that the legislatures might listen to him is a very different thing than offering him as an expert witness when the issue before this Court is not the social or political consequences or the social or political context, but rather the constitutionality of the legislation.

THE COURT:

But -- I'm sorry to interrupt. But I -- in the Attorney General's defense they have alleged that the Act is part of a comprehensive program, health program, and whatever the word "comprehensive" is intended to mean something else, but couldn't you say that that witness is directed at that specific allegation? What I'm going to make of it, I don't know, but it would be relevant to that allegation in the Plea.

Me CHERNIAK:

Let me answer it this way, My Lord...

THE COURT:

So therefore, if it's relevant, it should be admissible.

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Me CHERNIAK:

That goes to the issue of whether this legislation will be effective for the stated purpose, and that is whether this legislation will affect the consumption of tobacco products, because that's what -- that's what this overall legislative program must be, a legislative program designed to reduce the consumption of tobacco products. I don't contest for a moment that the Attorney General can call evidence, if it's otherwise admissible, by persons who have the qualifications to advise you on it, concerning whether or not the Tobacco Products Control Act will affect the consumption of tobacco products.

You won't hear me and -- or I think anybody else on our side contesting the admissibility of persons who are qualified to give evidence on such a subject. If this man was qualified to give such evidence, then I couldn't successfully object to it. He has purported to give that kind of evidence in his report. The problem is: he has no qualifications whatever to assist you on matters relating to the effectiveness of advertising or the initiation or continuance of tobacco use. So that to the extent that the report deals with that issue, it's not admissible, not because that issue isn't properly before you, but because he has no qualifications

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whatever to comment on that issue.

What my friend is saying is that when he gets into the social and political justification for the Act as being an appropriate interference with Charter protected rights, that you should hear him on that issue. And I say: that's not something that you can hear this witness or, indeed, any witness on, because that goes to whether or not the legislature should or should not have adopted such a program or legislation in the first place, not whether, having adopted it, it is an unwarranted interference with civil rights under the Charter, which is not protected by Section 1 as being that minimal interference with a protected right that is in effect permitted by the Section 1 test. In other words, the test that Mr. Justice Lamer outlined in the Motor Vehicle reference case. And that's a different issue. And this witness purports, I guess, in pages thirty-six (36) to forty (40) of his report, to deal with that issue, but in the first place, he has no qualifications to do so and, secondly, it's not something, in my submission, that even admits of expert evidence. The expert evidence ought to be the effect to which the legislation will have a certain effect that would -- that would allow to prove the facts necessary to show that it was the most minimal interference necessary and

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the like, the very -- the very considerations of the Section 1 test. That's not what this witness purports to do. This witness purports to say that it's all right to interfere with the civil rights involved, whether it works or not, because that will help change public opinion.

As Your Lordship has said, public opinion, the social acceptability of the legislation and the public opinion about it is simply irrelevant to the constitutional test, and thank God it is! Surely the constitutional cases aren't going to be decided and can't be decided on the basis of the social acceptability of the legislation. But that's -- if you read this report, that's what he's talking about. And I urge Your Lordship to read and re-read pages forty (40) and forty-one (41), because that's precisely the burden of this witness' evidence.

It's socially acceptable, and if it's not, this legislation will help make it socially acceptable. It's simply irrelevant to the test that you have to deal with.

Oh, I just should mention one or two other things, that my friend said. I wouldn't have thought that the admissibility of evidence makes any difference as to whether we're in a jury case or a non-jury case. I

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wouldn't have thought that that's got anything to do with the issue.

Me EVRAIRE:

Excuse me. I raised it in the context of bias.

Me CHERNIAK:

Well, I don't understand that. If his evidence is inadmissible, it's inadmissible whether it's a jury case or a non-jury case. It's a small point.

The -- and my friend said: well, this witness can talk about the -- he advises the City of Toronto and others, so he can talk from his personal experience. I say to Your Lordship this witness has had no experience whatever with the tobacco advertising ban, so that his expert evidence on the effectiveness of an advertising ban or the lack of it, he simply has no expertise to help you on that at all, so I don't understand that argument either.

Me POTTER:

Nothing to add, My Lord.

THE COURT:

Anything, Maître Evraire? We'll take the break now, and I'll think of it.

SHORT RECESS

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Me EVRAIRE:

Your Lordship, I hope it's all right. I've asked Dr. Hancock to come back in now that we've completed argument.

THE COURT:

Well, on the objection, I am not an advocate of under reserve judgments, but this is going to be one. At this stage I'm not -- I'm not going to decide the objection at this stage. I'm not in a position to do so. I have re-read the Oakes decision as well as the Irwin Toy decision and I've decided to take the objection under reserve and will allow Dr. Hancock to testify to his report. To his report.

Me EVRAIRE:

Dr. Hancock, please.

THE COURT:

But that doesn't mean that I haven't read -- I have read his report.

Me EVRAIRE:

I take that as a given, My Lord, so that we don't have to read it into the record.

Me BAKER:

Take it as a hidden message as well.

Me EVRAIRE:

Just for reference, so we have an exhibit number, may we

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mark the report of Dr. Hancock as the next AG number.

BY THE CLERK:

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Me EVRAIRE:

Q- Dr. Hancock, could you give the Court your views on what has been the historical importance of public health in our society?

A- Yes, certainly, the -- I guess the historical importance has been that the public health approach and, if you like the public health movement over the past hundred (100) to hundred and fifty (150) years, has been the major contributor to the improvement of the health of populations in the industrialized world, for that matter worldwide.

THE COURT:

You have a citation of Cicero. Is that?

A- Yes, I do.

Q- I think there's a mistake on it. The last esto -- Salus populi suprema lex "esto."

Me POTTER:

It's nearly certain the est, My Lord.

A- Yes.

Q- Dans une cause comme celle-ci, Votre Seigneurie, nous sommes portés à perdre notre latin.

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THE COURT:

Q- I think there is an o that shouldn't be there?

A- That's right, thank you.

Me BAKER:

You put in too much. And the last time Mr. Potter spoke in Latin, he left some off if you remember, about a year ago.

THE COURT:

Well, he -- he was good enough in shibboleth, but...

Me BAKER:

I'm talking about Latin. He's excellent in English.

THE COURT:

Oh, Latin, okay.

Me EVRAIRE:

Q- Doctor, are you able to give the Court some examples of public health measures which in the past simply have not worked?

A- Well, I suppose I've talked a bit before about the prohibition measure. Now, that was not strictly introduced as a public health measure but it was certainly a measure that had public health implications that didn't work.

I guess one could go back historically, for example, right here in Montreal and the latter part of the last century. There was an attempt to lynch the

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medical officer of health because the medical officer of health was introducing smallpox immunization in the situation of an outbreak and that was not very well received at the time.

I think the history of public health has been that things get tried and don't necessarily work and later on they are found to be useful and are introduced. So, there's a, if you like, a progressive nature to it, but certainly -- not so much things that didn't work but things that were opposed at the time and subsequently proved to be right, chlorination of water, building of sewers, a variety of measures like that, fluoridation -- fluoridation still has not been introduced here in Montreal, for example. It's an effective public health measure but it hasn't proven possible to introduce it yet.

Q- How would you characterize the public health approach to problems of disease?

A- It's a preventative approach. In other words, we're seeking to prevent the problem occurring in the first place.

Q- And, bear in mind, Dr. Hancock, that His Lordship has read your reports so that you needn't repeat anything that's already in your report but could you tell us what you consider the most important factors that come to

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play in public health decisions?

A- Well, in terms of making a decision in public health, the first concern is to really have some sense of the magnitude of the problem you're facing. What sort of a health problem is it and how many people are affected, how seriously are they affected. Then, what is the potential for prevention of that problem, because we're interested in preventive measures, and that's a combination of not necessarily understanding the full mechanisms of the -- of the problem. I think, for example, of the famous story of John Snow and the Broad Street pump, which is a piece of public health, both history and legend in a sense. He stopped an outbreak of cholera in the nineteenth century because he recognized from the data he had collected that the people who were falling ill had been taking water from a particular pump. The mechanism wasn't really understood but he felt that if he literally were to disable that pump, he would be able to stop the outbreak and, in fact, that's what happened. So, in other words, the mechanism on that wasn't understood, the bacteria for example that caused that problem weren't identified at that point. So, to a certain extent, you need to understand the mechanism of the disease but you don't have to understand the full mechanism before you take

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action.

Q- Let's understand the role of the different players. You indicated that, in your experience, you have been a medical officer of health?

A- M'hm.

Q- What role does the medical officer of health play in public health decisions themselves?

A- They are -- they really fulfill two (2) quite related functions. One (1) is as an expert in public health and in -- particularly public health from the medical perspective, but secondly as the chief administrative officer of a public health department so as a -- as a bureaucrat, if you like, and as an advisor. So their role is both to identify what -- what is the scientific medical and public health evidence and also to then work with politicians with the bureaucratic system within that to develop appropriate remedies and to propose them where necessary.

Q- Does a medical officer of health deal with the elected officials in that area?

A- All the time.

Q- Can you give us a day to day example of that?

A- We have -- well, if you take Toronto, we have a board of health in Toronto and the board of health really is responsible for -- over policy direction and so the

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medical officer of health would take directions from the board, make reports to the board. One could, for example, think of the -- well, again, the non-smoking by-law. That was a process of working with the Board of Health to arrive at suitable legislation which was then recommended to city council.

Q- Who, in your view, is ultimately responsible for controlling disease in our society?

A- Well, there is no one person. It partly depends on what disease you're talking about. It is essentially a collective responsibility. There is certainly an individual element to that, but certainly from the public health point of view, health is a collective and, if you like, a state responsibility. Now, within that there is a whole range of players who are involved and it ranges all the way from individual behaviour through to state legislation.

Q- Now, let me ask you on what basis decisions are made in the public health field. Let me back up for a moment. Does one refer to the public health field or public health discipline? What's the expression that you use?

A- I'd say the public health field.

Q- All right. Now, what is are bases for making decisions in that field and who are the players that make those decisions?

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A- To a certain extent, it depends upon the nature of the decision. Clearly minor decisions or decisions within an existing framework of rules and regulations are made by the medical officer of health or, indeed, by public health inspectors, for example, acting within, for example, the Health Protection Promotion Act. When you come to decisions with respect to new policies, programs and so on, those decisions are usually made by the medical officer of health or the -- if we're talking at the provincial or even federal level, by the senior bureaucrats in consultation with political leadership and obviously where legislation is required, it's ultimately the legislation, the legislators that make the decisions.

23/007315 Q- Does that interplay between these various players change or is it the same when you have a new disease such as the advent of AIDS in our society, for example?

A- Well, I think if you look at the history of AIDS, it has been a combination, in some respects, of political leadership and obviously of public health leadership.

Q- M'hm.

A- So we have seen one of the big issues in fact has been around the so-called politicization of the research process in AIDS and, in fact, influential decision or major influences of decisions there have been in that

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case both the people who have AIDS and people who are at high risk of getting AIDS. So there has been a substantial community input as well into the decision making.

Q- Doctor, one of the many criteria that you referred to at page twenty-eight (28) and twenty-nine (29) of your report -- and you might refer to that if you wish -- in addition to the nature and severity of the problem, as you highlight them in sub-components on page twenty-nine (29), and the existence of remedy, there is the social and political acceptability about which we've had some discussion today. How does the social and political acceptability factor into the decision making -- let's take the situation of AIDS now-- how does the public health official play that role in terms of, say, the advent of a new disease that has to be tackled?

A- Well, sometimes it's a matter of almost, as it were, leading what -- social and political acceptability. For example, in the case of AIDS, I think that it would have been socially and perhaps even politically acceptable in the early part of the outbreak to take AIDS victims and lock them up. There was a lot of public concern, a lot of public pressure. In that instance, the role of the public health professional, the role of people addressing the AIDS problem was, in fact, to say: "No,

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it's not that severe a problem. These people are not sort of contagious and you can touch them and talk to them and so on", but there is no justification for the more extreme measures that are being proposed.

Q- And how can we determine if the public health measure which has been arrived at is an appropriate measure? What is the test to determine if it's appropriate?

A- Well, I'd say that there are several tests in fact. One test is whether or not it proves to be socially and politically acceptable. Another test is whether or not it works and...

Q- It works in what way?

A- Works in the sense that it has the intended effect and helps to reduce the incidence of that particular health problem.

Q- All right. Have I cut you off now in describing the different tests? All right. Now, at page thirty (30) of your report you do address the question of public good and private rights.

A- M'hm.

Q- How do public health measures restrict individual rights in your view?

A- Well, in a great many ways, and it depends very much upon the severity of the problem. I suppose at its most extreme, we have public health measures that enable us

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to order people not to carry out certain forms of work, we have legislation such as seat belt legislation or motorcycle helmet legislation that requires you to take a particular measure to protect yourself, so in a variety of different ways that I've spelled out here, public health legislation interferes with your total right -- your right to total freedom.

Q- What's the good to society, take the example of the seat belt legislation, that you see?

A- Well, the good to society is that motor vehicle accidents are a major cause of death and disability and they cost a great deal of money to society in addition to the pain and suffering in terms of medical care. And we have an appropriate and simple remedy to prevent the problem -- or to substantially prevent the problem anyway.

Q- Was that, in fact, a public health decision in your view?

A- Yes, I mean a lot of the pressure for seat belt legislation came from the public health sector, broadly defined, as well as, obviously, from the community, from consumer advocates. It's one of those areas where the people such as Nader in the United States, would put himself down as a consumer advocate, but he was in effect playing a public health advocacy role in pushing

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for those sorts of rules and regulations.

Q- Do only doctors play the public health role?

A- Oh, no.

Q- In a society.

A- No, not at all. The public health role in the professional sense is -- in itself covers a number of different professions of which medicine is only one, but beyond that, a huge number of people play a public health role including politicians, community leaders, consumer advocates, environmentalists, just ordinary folk, if you like.

THE COURT:

Mr. Evraire.

Me EVRAIRE:

Yes, sir.

THE COURT:

You brought Doctor Hancock as a medical doctor who has specialized in a field in a specialty of medicine which is called public health.

Me EVRAIRE:

Yes.

THE COURT:

If I understand well his report. You shouldn't try to water down the importance of that.

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Me EVRAIRE:

No, I was hoping, My Lord, that he would, as indeed he did, explain that others have input into the process, but let me zero in on that particular aspect.

Q- If there are different players in the public health role, what does the physician bring to that particular public health role?

A- Well, I think the physician, first of all, brings a knowledge of and experience of disease, of people who have disease and of the pathology, pathogenesis of disease, which is part of a basic medical education. And then the further training that a public health physician undertakes marries to that a knowledge of epidemiology and a whole range of public health measures. So what you have is both a good understanding of disease and disease process, and added to that an understanding of public health and epidemiology.

Q- You've explained that you had such a role with respect to tobacco in the City of Toronto. Explain to us, if you will, how you played that role as the physician, given those particular disciplines that you brought to bear?

A- Well, I think that probably what I brought to that, in a sense, was firstly an understanding of the pathogenesis of the tobacco-related diseases.

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Q- Could you define that please?

A- Pathogenesis?

Q- Yes.

A- Pathogenesis is the -- is taken from a patho, meaning disease, and genesis, the genesisal generation of disease, so what are the antecedents of disease, what are the causes of disease.

Q- M'hm. Go on.

A- And I think, secondly, just the experience of having worked in the hospital and worked in practice seeing the consequences of tobacco smoking, seeing lung cancer, chronic bronchitis, and heart disease and so on.

Q- You saw these in whom now?

A- Oh, in patients when I was a medical student and as a family physician.

Q- All right. And what about epidemiology. Did you rely on that particular discipline...

A- Very much.

Q- ...in that work?

A- Very much.

Q- In what way?

A- Well, epidemiology is one of the main ways of establishing the link between smoking and the various diseases related to smoking. So an understanding of epidemiology is important if you're trying to establish

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that link.

Q- Now, Doctor, why do you not say that we should simply ban tobacco, given what you feel about it?

A- Well, I think it's neither socially nor politically acceptable nor feasible at this point to do something like that. I think that our experience, again, I go back to prohibition as perhaps the closest analogy. Our experience is that those approaches don't work. And it's not reasonable that they would.

So it's not feasible to ban tobacco.

Q- Therefore, what do you say is the appropriate response to, at this point in time, deal with the tobacco-related disease?

A- Well, the appropriate response is to take the toughest measures that you can, the measures that are the toughest, that will -- that are politically and socially acceptable. That will contribute to the reduction in smoking.

Q- You say "measures". You mean more than one (1) measure is necessary?

A- Oh, absolutely. One of the key elements of any effective public health strategy is that it needs to be what's known as -- well, actually, there is three (3) ways of thinking of it. It needs to be multi-faceted -- that is to say you don't just educate, you also

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legislate and you do community development and a whole bunch of other different strategies. You use multiple education strategies for that matter. It needs to be multi-sectoral inasmuch as seldom is it simply one part of society or one sector that has the answers or has the powers and it really needs to be multi-level inasmuch as it's everything from individual action to national action and different levels of jurisdiction in between.

Q- Specifically now, what are the measures that you feel are appropriate in this broad range of approaches?

A- Specifically with respect to tobacco?

25/0041 Q- Yes.

A- Well, I suppose if one were to take it, as it were, from the bottom, the first measure is education. At the bottom level in dealing with the individuals, so educating individuals about the hazards of smoking, in particular working with children, because what we really want to do if we can is to prevent people taking up the tobacco habit in the first place. Once you take up the habit, then it's much more difficult to give up, as anyone who's smoked knows. So you're looking there at individual educational measures.

Moving up from that, we know a good deal now about the importance of creating social environments within which it's possible to give up smoking. One of the

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reasons, for example, why the anti-smoking or the work place smoking bylaw in Toronto has been so successful is because a good proportion of smokers themselves accept that sort of legislation, in part apparently because it helps them to quit smoking. So you're creating the social environment in which smoking becomes socially unacceptable.

That's been a major change, I think, in the last ten (10) years in Canada, is that smoking has shifted from being socially acceptable to being socially unacceptable, just as hawking and spitting did back in the nineteenth century. You don't see that very much now. You certainly don't see spittoons in the way you did a hundred (100) years ago. So the social environment has changed.

Then a variety of public policy measures, including the elimination of tobacco advertising and promotion, but also looking at price increases since we know that increase in price is another effective way to reduce demand. Looking at phasing out or reducing the support to tobacco farming and finding ways of reducing or helping farmers to get out of tobacco farming. So it's a very wide range of policies and programs and efforts that are required.

Q- You...

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A- And those...

Q- Go ahead.

A- And those range, as I say, from the individual to the community to the work place to the municipality and on up to provincial and national governments.

Q- You referred in your report to the national program to reduce tobacco use in Canada.

A- Yes.

Q- What have you learned from it that is of benefit to you as a public health professional in the fight against tobacco use?

A- Well, I think what that program does is in fact to or that directional paper does is to pull together what I was just describing and talk about a comprehensive long-term broad strategy. So in a sense, it's not so much what one learned from the paper as that the paper pulled together a lot of what was already known into a comprehensive approach.

Q- You've also made reference at page thirty-eight (38) to the World Health Organization's position on tobacco use.

A- Yes.

Q- Do you consider it important to look at what the W.H.O. has been doing in this regard?

A- Oh, I think it's very important. I think the World Health Organization is after all the -- the leading

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global authority on health and they set, in may ways set the standards for national programs.

Q- And have any of the positions of the World Health Organization been -- excuse me, have any of the positions you've expressed today been inconsistent with the World Health Organization approach to tobacco use?

A- No, I don't believe so.

Q- All right. Can I just have a moment, My Lord.

THE COURT:

Do you want me to take a walk?

Me EVRAIRE:

No, no.

Q- Now, this morning you'll recall, Dr. Hancock, as we looked over and discussed your qualifications, I put to you the question whether or not you felt it was necessary that a remedy be seen as successful before it was even suggested by a public health official. Do you recall that?

A- Yes, I do.

Q- In the context now of your report, I put that question to you again and ask if it is important for you as a public health professional to see that a remedy will, in fact, be successful before you even recommend it or put it forth to the political masters you've spoken of?

A- No, I don't think you can necessarily say that it will

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be successful, I think that, again, I would go back to the concept in the Health Protection Promotion Act, that one should have reasonable and probable grounds to believe that a health hazard exists and have, for that matter, reasonable and probable grounds to believe that you can do something about it. So if we have some reason to believe that, in this instance, a ban on advertising may reduce smoking or may contribute to a reduction in smoking, or may contribute to an inducement, a reduction of the inducement to smoke, that's -- that's enough, particularly given the nature and severity of the problem we're attempting to deal with.

Q- And let's say someone put to you the proposition that: listen, believe me, it's not going to work! Would that dissuade you from that course of action?

A- Not necessarily. I think in part because, until we try it, we don't know whether that's so or not. And in this instance, again, given the nature and severity of the problem, I think that what also is weighed in the balance, if you like, in those sorts of decisions is whether or not the problem we're dealing with is a severe problem, so that one might, in the case of a mild problem, given that situation, say it's not worth the trouble, but in the case of this sort of severe problem,

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I think one would say, it's worth doing it and we think it may have an effect and it's worth trying.

Q- Is tobacco or are tobacco-related diseases a problem that's particular to any part of the world?

A- Well, at this point it's primarily a major health problem in the industrialized world, although what is beginning to happen is that the marketing of tobacco to the industrializing world, to the developing world is beginning to happen. The tobacco industry seems to have recognized that that's the next big market to exploit.

Q- Does that require that there be considered action by public health officials throughout the world?

A- Oh, very much so. And that's one of the big problems, because very often the legislation and regulations that we have in place here are much tougher than will be the case, let's say, in a developing country.

Q- But -- go ahead.

A- Sorry. But clearly what is the intent and certainly what the World Health Organization is seeking to achieve is that -- that countries all over the world begin to adopt these tougher policies.

Q- And what level of communication exists between public health officials with respect to tobacco problem, to your knowledge, throughout the medical community in the world?

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A- Oh a very -- very high level of communication for one thing, at the World Health Organization, through its tobacco program, through such things as the World Conference on Smoking and Health and so on. So there's an extensive communication.

Q- Do you see these as part of the public health approach.

A- Yes.

Q- Do they fit in that definition?

A- They fit in, yes, because what they are attempting to do there is to educate, in this case, public health professionals and help them to develop their thinking about tobacco and health.

Q- Is there any particular group that you can identify that has attacked tobacco use more than others?

A- Well, I would say the health community in general within Canada, for example, most of the major health organizations at one time or another, medical and professional associations, and so on, have been part of the move against tobacco. So that covers the Canadian Medical Association, the Canadian Public Health Association, Canadian -- the heart and lung and cancer societies and so on.

Q- All right, Doctor, I thank you. Those are my questions.

Me CHERNIAK:

Mr. Potter is going to go first, My Lord.

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THE COURT:

Well...

CROSS EXAMINATION Me SIMON V. POTTER,

On behalf of the petitioner Imperial Tobacco Limited:

Q- Doctor, we only have about ten (10) minutes before we get going tomorrow, so we'll see each other again tomorrow but maybe in the few minutes that are left to us, I'd just like to set ourselves parameters. I think it's safe to say that you believe tobacco causes several diseases?

A- I think it's safe to say, yes.

Q- Safe to say. In -- as a matter of fact, you -- you see those diseases as societally influenced forms of self-abusive behaviour. Is that -- is that fair to say that you've written, as in exhibit RJR-172, which is this article that you wrote?

A- I don't particular recall that phrase...

Q- Well, we'll have a look at it, RJR-172, it's at page three twenty-one (321), the first paragraph as a matter of fact. The bottom lines of the first paragraph.

A- Right, yes.

THE COURT:

Where are you -- where are you?

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Me POTTER:

The last sentence, My Lord, of the first paragraph of the article.

THE COURT:

Many of the latter can perhaps...

Me POTTER:

Q- So, in that sentence, Doctor, I see that you're making a distinction between diseases on the one hand and on the other hand behaviors which result in a disease, is that correct?

A- In the sense that the disease is the end state, yes.

Q- Yes, and I think I heard you say in answer to Mr. Cherniak's questions that the consumption of alcohol itself is not a disease although it results later on in some problems?

A- It can be a disease if it becomes alcoholism.

Q- If it's alcoholism?

A- Which is defined as a disease.

Q- Right; and similarly poor nutrition itself is not a disease but it is a problem which results in disease sometimes, is that correct?

A- That's right.

Q- Yes.

A- Although, again, if you are -- if you are malnourished to the point of kwashiorkor, which is a particularly

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severe form of malnutrition in -- principally seen in developing countries. But certainly, I mean, that is a form of dietary deficiency that is a disease. For that matter, or form -- there's a number of forms of dietary deficiency that are -- become a disease.

Q- Yes, the fact of having poor eating habits, though, that's not a disease, is it? It's something that...

A- No.

Q- ... might give you a problem later on?

A- That's right, yes.

Q- And in your view, Doctor, is there such a thing as a healthy smoker and does that exist somewhere?

A- There are smokers who I suppose, at any one point -- it depends what you mean by healthy? I mean that's part of a problem.

Q- Well, I'm asking you. Is there such a thing as a healthy smoker? Does it exist or is everyone from the time he has that first cigarette suddenly sick?

A- No, I don't think they're sick in that sense. I'd say that they are much more likely to become sick as a consequence of their smoking.

Q- So smoking increases the risk of their eventually becoming sick?

A- Yes, very much so.

Q- Now, I read from your reports, doctor, that you have

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made some very important contributions, it's at page two (2) of your report, and we see in the third paragraph there that you have made three (3) major contributions in the field of public health, and one (1) of them, I think, we have just about enough time to speak about, is the concept of a healthy public policy -- and that's actually the one you referred to as your second important contribution?

A- That's right.

Q- And you say in your report that six (6) years ago, in nineteen eighty-four (1984), you organized the first conference on this topic -- on the topic of a healthy public policy. Doctor, I want to give you a chance to set us straight. That doesn't mean that nobody thought of healthy public policies before six (6) years ago, does it?

A- No.

Q- No, and, in fact, the terms were used, healthy public policy, before six (6) years ago?

A- As far as I'm aware, the first time it was used was as -- as that term of healthy public policy was used by myself in, I guess, about nineteen eighty-one (1981) or two ('2).

Q- Nineteen eighty-one (1981) or two ('2). So what happened in nineteen eighty-four (1984) was that you had a

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conference?

A- That's -- yes, that's what it says, the first conference.

Q- Yes, and for how long has the public health field been interested in the idea of a healthy public policy, Doctor, whether it was called that or something else?

A- I'd say the idea has been around as long as public health in a sense, but that particular conceptualization of it and that understanding of it, I think, is relatively new.

Q- Well, excuse me, you write here:

"My second important contribution was the development of the concept of healthy public policy."

A- M'hm.

Q- Now you say that the idea of a healthy public policy is something which has run through the whole history of public health, is that correct?

A- M'hm.

Q- So what you did in nineteen -- whenever it was, nineteen eighty-one (1981) or nineteen eighty-four (1984), I suppose you came up with your own ideas as to what a healthy public policy is?

A- Yes, I developed that concept. That is to say, I developed it further and ...

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Q- Oh, I see.

A- ...I, in particular -- I, in particular, created the term healthy public policy.

Q- All right. Well, let's take those one (1) at a time. First of all, what you -- what you mean by saying the development of the concept of healthy public policy was that you brought something to the table and added to the ideas of what should be a healthy public policy, is that correct?

A- Yes, well, both what should be and therefore what was the notion of a healthy public policy, yes.

Q- Now, you say:

"The concept ..."

-- in the last sentence of that same paragraph --

"...has subsequently become a key strategy."

What are you talking about there, Doctor? Is it the concept which has run through the whole history of public policy, of public health, or is it the idea that you came up with in nineteen eighty-one (1981) or nineteen eighty-four (1984)?

A- Well, I think what happens is these things go in historical cycles and that no one had particularly -- certainly no one had talked about healthy public policy in that way for quite some time. What happened in particular as a consequence of the development of that

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concept and of the conference that we held was that the notion of healthy public policy and the use of the term healthy public policy, for that matter, became fundamental, became central to, in particular the Ottawa Charter for Health promotion. And also for the Achieving Health for All, which is the Federal framework for health promotion.

Q- But what...

A- So if you like, there were people, perhaps, out there looking for the way to frame and phrase this concept, and what the conference and what my work in the area did was to provide the means of doing that.

Q- Well, just what was this concept?

A- Well, the concept is that the nature determinants of health are beyond the health care sector, which is why we called the conference: Beyond Health Care. And that therefore public policy in non-health sectors was an important determinant of health and therefore we needed to look at how do you make those public policies health-promoting.

Q- Well, the installation of sewers in a municipality.

A- M'hm.

Q- Isn't that beyond what you call the health care sector?

A- Yes.

Q- And the idea of building hospitals, I suppose you would

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say that is within the health care sector?

A- That's right.

THE COURT:

Well, I suggest that we go into these specific questions tomorrow morning.

Me POTTER:

Thank you, My Lord.

THE COURT:

Ten o'clock (10:00)?

Me CHERNIAK:

My Lord, I will not be here tomorrow. Mr. Mitchell will carry on the cross-examination after Mr. Potter.

THE COURT:

So we'll hear the voice of Mr. Mitchell.

ADJOURNMENT

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CANADA
PROVINCE DE QUÉBEC
DISTRICT DE MONTRÉAL

COUR SUPÉRIEURE

SOUS LA PRÉSIDENCE DE L'HONORABLE JUGE JEAN-JUDE CHABOT, J.C.S.

No: 500-05-009755-883

RJR-MACDONALD INC.
Requérante

c.

LE PROCUREUR GÉNÉRAL DU CANADA
Intimé

No: 500-05-009760-883

IMPERIAL TOBACCO LIMITÉE
Requérante

c.

LE PROCUREUR GÉNÉRAL DU CANADA
Intimé

20 mars 1990 - Vol. 49

COMPARUTIONS :

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In the year of Our Lord nineteen hundred and ninety (1990), on this twentieth (20th) day of the month of March, PERSONALLY CAME AND APPEARED:

Me DOUGLAS MITCHELL:

For RJR-Macdonald, Doug Mitchell. My Lord, I'd also like to point out Maureen Currie who has been making Earl Cherniak look so smart for the past three (3) weeks. This is her last day here probably for a while but I just thought, since you hadn't -- nobody had mentioned her name, I thought I'd better do it.

THE COURT:

Thank you, we appreciate.

Me SIMON V. POTTER:

For Imperial, Simon Potter.

Me PAUL EVRAIRE:

For the Attorney General, Roger Baker, Claude Joyal and Paul Evraire.

THE COURT:

Je m'excuse de mon retard, messieurs. J'avais rendez-vous chez un médecin avec mon garçon et ça a été plus long que prévu. J'ai, avant de commencer, apporté pour votre information personnelle un bulletin de l'Association pulmonaire du Québec que j'ai reçu par la poste. J'ai pensé vous en faire une copie et vous le

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remettre. Entre autres -- ce n'est pas de la preuve et je tiens à le dire tout de suite, là -- mais je l'ai lu pareil, mais comme je ne suis pas un jury, je suis capable de faire abstraction...

1/0064 5 Me EVRAIRE:

Très bien, Votre Seigneurie.

THE COURT:

... de ce que je lis et de ce que je connais. Alors je vais vous en remettre une copie et vous me direz. On y trouve entre autres que les jeunes fument surtout à cause du milieu familial. On fait référence à une étude réalisée en novembre et décembre quatre-vingt-neuf ('89). On offre un cours pour cesser de fumer à vingt-trois piastres ($23.00). Enfin, vous verrez. C'est intéressant. Je présume que ça m'est arrivé purement par hasard. Je suis sur une liste quelconque. Procédons.

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In the year of Our Lord nineteen hundred and ninety (1990), on this twentieth (20th) day of the month of March, PERSONALLY CAME AND APPEARED:

TREVOR HANCOCK, forty-one (41) years of age, residing at [DELETED]

WHO, having made a solemn declaration, doth depose and say as follows:

CROSS-EXAMINATION BY Me SIMON V. POTTER (CONTD),
On behalf of Petitioner, Imperial Tobacco Limited:

Q- You haven't changed your age since yesterday?

A- No. I'd like to sometimes.

Q- Well, Doctor, yesterday -- not to spend too much time on it again this morning -- we were speaking about one of those three (3) contributions you made, which is mentioned at page two (2) of your report, and we were talking about your development of the concept of healthy public policy.

A- That's right.

Q- And just to summarize, I think it's fair to say that it wasn't you who came up with the idea of a healthy public policy. That idea has been around for a long time. You perhaps came up with the word or the term "healthy

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public policy" and developed the concept a little further than it had already been developed. Is that true?

A- Yes, and I think what I did with that was to bring it together in a package in a way that it hadn't been really put together before.

Q- Well, how was that package new?

A- I think because it explicitly dealt with the fact that public policy for health had to be thought of as a strategy separate from health care policy and it was the bringing together of all of the different interest groups and the different -- the conference, for example, in nineteen eighty-four (1984) was really, I think, about the first time, certainly the first time that anyone that I have talked to has been aware of when we really brought together all of these diverse areas of public policy, that impact upon health was studied to try and look at them as a whole.

Q- I think it was not new though, Doctor, that all those areas have always been involved in public health in one way or another.

A- Yes, that's right.

Q- In fact, since the day we've been shooting rabid dogs, we've been having things done as public health which fall outside health care?

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A- That's right.

Q- And you say that this concept of yours -- and what was the concept? That everyone had to work together or that everyone was involved?

A- I think the concept was to see public health as more than concerned with traditional health care or even, for that matter, with what had become traditional public health. There really had not been a lot of work in this area, in this way of thinking about public health in the past couple of decades. It had been -- bits of it had been around, it had been spotty, but it was that pulling together of the whole thing and seeing that as a major thrust to the public health, and I think that was what caught people's attention and made it, therefore, a central component of what was emerging as the new public health.

Q- Well, you say that the concept was -- in fact, became a key strategy in the health promotion programs of world health?

A- That's right.

Q- I don't think world health has ever believed that it's only a question of health care, have they?

A- No.

Q- No.

A- But in terms of the Ottawa Charter for Health Promotion,

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which is widely seen as the development of a new public health and the -- like the flagship of the new public health, particularly in the context of the industrialized world, that concept of healthy public policy and specifically that term, "healthy public policy," became one of the five (5) elements and in fact the first of the five (5) elements or strategies for health promotion, and went on to be the theme of the Second International Conference on Health Promotion in Adelaide in nineteen eighty-eight (1988).

Q- This term, "healthy public policy?"

A- The term and the subject matter it encompassed, yes.

Q- Well, and then we go to your third important contribution, a workshop: "Healthy Toronto 2000," and what was special about that? I don't think nineteen eighty-four (1984) was the first year Toronto thought of being a healthy city, was it?

A- No, we actually put out our mission statement, in fact I wrote that mission statement in nineteen eighty-one (1981) or two ('2), I suppose it was, that the mission of the Department of Public Health was to make Toronto the healthiest city in North America. So we had been thinking about: how do you make a city more healthy. Really, I guess, starting in the Advocacy Unit is where we first started to put that together in the early

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nineteen eighties (1980s).

What the workshop did, as with the conference, was to take these ideas and begin to put them together and to discuss them, and it was -- it was that that caught the attention, in fact, of Ilona Kickbusch and led to her developing the healthy cities project in Europe.

Q- So there, again, Doctor, are we talking about ideas that had always been there and been around, but you presented a conference which put them altogether in one place?

A- Yes, I think that's fair to say.

Q- All right.

A- And it was that bringing together and, if you like, relaunching. I mean, as with what we've been seeing, I think, in the last ten (10) or fifteen (15) years since the Lalonde report and so on has been what many have referred to as a Renaissance of public health. And with that Renaissance has come the Renaissance of ideas that really haven't been in the forefront of public health thinking for several decades.

Q- Well, let's go on to your other major contribution, the one that is spoken about in the middle paragraph on page two (2). And this is what you call the "mandala of heath?"

A- Right.

Q- In lowercase letters on page two (2), but in uppercase

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letters on page eighteen (18) of your report?

A- Yes.

Q- Yes. And first of all, a mandala, you describe on page eighteen (18) as a circular symbol of the universe?

A- That's right. That's the definition taken from Chambers Dictionary.

Q- And if we go to your diagram of the mandala on page nineteen (19), do I take it, Doctor, that this is what you mean by the mandala, this diagram. This is what you came up with?

A- Yes, that's right. This is a slightly later version of the one that we originally had.

Q- That's right. Because the earlier version spoke not of human-made environment, but man-made environment, didn't it?

A- That's right.

Q- And you changed it to avoid appearing sexist?

A- Yes.

Q- But you didn't change it into the Hugh Mandala of health, you left it "mandala of health." It would sound too much like Nelson's brother, I suppose if...

In any event, in the mandala of health it used to be -- it used to refer to the man-made environment. There were other changes too, weren't there?

A- The major one, as I recall, as we developed it further,

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was the addition of work on the right-hand side and I think we changed the term "sick care system," it was originally, I think, "medical care system." I don't recall exactly.

Q- I suggest it was "health care system."

A- That may be.

Q- And in the circle on the top right which refers to the psycho-socioeconomic environment, what did that used to be?

A- I don't exactly recall. Probably the psycho-social environment.

Q- The psycho-social environment. Why did you later decide to add economic?

A- Well, I think that as with any idea that's developing as people looked at it, they said: well, we don't see, for example, some -- we don't see work, and where is work in this, and we looked at it and felt that indeed we'd missed an important category in work, and so we added to it. So what happened was an evolution of the concept. I'd say partly an evolution, mostly a refinement. For example, adding economic to the psycho-social environment was really an attempt to address the socioeconomic aspect of health without, if you like, without destroying the balance of the model and to recognize that the three (3) are quite closely linked.

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Q- Right. Well, I think I'm not putting words in your mouth, Doctor, by suggesting that the reason you wanted economic in there was to make the thing as global as possible. You're looking at all the influences which are possible on health?

A- Yes, I think it was partly that and it was also because we felt that we hadn't included sufficiently the economic aspect of health.

Q- You wanted to make it as universal as possible. It's a universal symbol, a symbol of the universe?

A- Yes.

Q- You wanted it to include everything?

A- It's a comprehensive broad model.

Q- Yes.

A- I'm sure it doesn't include absolutely everything.

Q- Well, we'll get to that in a minute, find out what it doesn't include. In any event, it starts off being as wide as the biosphere?

A- That's right.

Q- That's -- that's the whole world in which we live, isn't it?

A- Ultimately, it's the whole world.

Q- Yes, in fact, right up to the stratosphere?

A- Oh, very much so. One (1) of the things we're concerned about at the moment from a health point of view is the

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destruction of the ozone layer, which has some quite unpleasant health consequences.

Q- Yes, and in the very middle of the mandala of health is -- I take it that's an individual?

A- That's right.

Q- Either a man or a woman but a someone, an individual?

A- That's right, a non-sexist.

Q- A non-sexist. Well, that's something else that you've changed, isn't it doctor, from your original version of the mandala of health? The individual in the middle was simply presented as an individual. I show it to you in RJR-171 and -- and since then, he has become identified as having a body, mind and spirit?

A- That's right.

Q- Is that right?

A- M'hm.

Q- Yes, why did you do that?

A- I think we were trying to reflect in that a -- a focus on the elements at the individual level that -- that people are concerned with. So -- and the notion of body, mind and spirit is particularly a notion associated with holistic health approaches, so in the holistic health field people often talk about body, mind and spirit and we were trying to reflect that aspect of human health.

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Q- And what to you is the spirit?

A- Well, I suppose at one level it's -- it's an extension of a notion of mind. It has to do with one's spiritual essence for those who believe in such a thing. Not everybody does.

Q- Now, am I right to say that this is a highly individual thing. My mandala is not the same, necessarily, as your mandala, is that correct?

A- I suppose one could argue that. I would say that this mandala, which I have used in my work and in teaching and so on for many years now, has been well recognized and accepted. A lot of people find it a useful way of trying to understand some of the elements that make for good health.

Q- I understand that, but my question is: everyone has his own mandala? You pronounce it mandala, everyone has his own family background, doesn't he? My family background is not the same as yours so I'm in a slightly different context from you, am I not?

A- That doesn't affect the model though. The point about the model is that this is a way of understanding the elements that are determining human health, so that certainly your family background may be different from my family background, but we both have, in common, a family background unless...

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Q- Yes, I understand that.

A- ...you resulted from a test tube.

Q- Doctor, I'm not suggesting you ought to have a different diagram like this for every individual in the world. I'm just trying to..

A- That wasn't...

Q- ...get at the -- your idea of what the mandala of health means. It doesn't mean that everybody is living in exactly the same situation with exactly the same influences and with exactly the same background and with exactly the same environment, does it?

A- What it means is that everybody lives within a culture, within a community, everyone has personal behaviour. It's a universal model in that sense.

Q- Sure. But I have my personal behaviour, you have yours?

A- Of course.

Q- Yes. I have my family background, you have yours?

A- Of course.

Q- And, in fact, I have my culture, other people in this room might have a different culture?

A- Not exactly in the sense that we were using that. We all share, in many ways, a common culture. We are -- we have a common Judeo Christian culture for the most part in this country. Certainly our -- our organizations and our -- for that matter, our laws in our particular

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systems have a common root. So, culture in this sense is used in a rather broad sense but I think we all share a common culture in many respects. Our culture is not that of a -- it's not an animist culture in the Amazonian forest, which would be a very different culture.

Q- Yes. Okay, now where does education fit in here?

A- Well, education is a strategy for make -- creating changes within here, so that what we've also said about this model, it's -- it's clearly quite a complex model, and what we have said about the -- the mandala, in fact, is that you can look at a number of different ways of changing the determinants of health here so that you can look at education as, broadly speaking, operating of the inner levels of the level of the individual compared to community development, compared to social and political change so that -- which operate at, if you like, higher levels of the model so that education is one (1) of the strategies for creating change within that model.

Q- But education is a determinant of health, to use your term?

A- Yes, in that sense, if you're talking about level of education and so on, I would say it probably fits in the level of psycho-socioeconomic environment. In other words, part of your psycho-social environment reflects

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your -- your level of education.

Q- M'hm. And in making those choices about lifestyle, I think it's your view, is it not, Doctor, that people are -- people can be made victims of the pressures to which they're subject?

A- Yes, that's right.

Q- And people need protection from those pressures if the pressures push them the wrong way?

A- Yes, they need protection, they also need education, they need a variety of things. Protection is one (1) of the strategies to deal with those pressures.

Q- Right, and is one (1) strategy to get rid of the pressure?

A- Yes, if you can, if that -- if that makes sense.

Q- Now, what happens, then, to the question of people being responsible for their own choices about the way they want to live, Doctor? You've written that:

"Health behaviors are not amenable to appeals based on personal responsibility."

A- I'm sorry, where have I written that?

Q- I think you have written it at page eighteen (18). It's in the very middle of the page eighteen (18).

"Health behaviors are not amenable to simplistic appeals to behavioral change based on an ideology of personal responsibility."

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I want to know what you mean by this because what you have said is that what we -- what we have to do is protect these people because they are going to make some wrong choices...

A- No, I also...

Q- ...subject as they are to the pressures that they are subject to?

A- Let me correct you, what I said was that one (1) of the strategies is to protect people. There are other strategies, including educating people.

Q- I agree there are many strategies.

A- Right.

Q- But you have said that, to the extent possible, you want to protect them?

A- Certainly.

Q- And to the extent possible, you'd like to free them of the pressures which pushed them the wrong way?

A- Of course.

Q- Yes. Now, what do we do about personal responsibility? You've written here that you can't get behavioral change by appeals based on personal responsibility?

A- No, I've said you can't get them by simplistic appeals based on an ideology of personal responsibility.

Q- Well, what does that mean, Doctor? Does it mean you can get them...

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A- Well, what that means...

Q- ...if you have complex appeals?

A- Yes, in a sense it does. What that means is that to simply, as is often the case, tell people that they should simply stop smoking, it's bad for them. It doesn't work.

Q- They keep doing it?

A- A lot of people keep doing it and they keep doing it for a variety of reasons, including the fact that they may be addicted to tobacco, including the fact that they have a variety of social cues and their friends, for example, smoke, and a variety of other reasons that make them continue the habit. So simply educating people is not sufficient for change, and that's underlying -- understanding of public health, that education alone doesn't work or, at least, it doesn't work as much as education combined with a variety of other strategies.

Q- You said it will not work alone. You've got to combine it with the strategies on the outer limits of the mandala?

A- I think what you can do with education is you can achieve some change but you will not achieve anywhere near as great a change simply with an educational strategy -- strategy, particularly a simplistic educational strategy based on a personal responsibility

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approach, you will not achieve as great a change or as sustained a change with that as you will with a longer term comprehensive program.

THE COURT:

Why -- why would the simplistic approach not work? There has to be reasons why it doesn't work?

A- Well...

Q- Forget cigarettes, think of food, think of alcohol?

A- If -- if it was...

Q- Think of sports, think of a number of lifestyles?

A- If it was simply a matter of education, then very few people would smoke. I don't know how many of the people here smoke but it's -- it's difficult for me to understand intellectually, if you like, why anyone would continue to smoke, having sat through and heard the evidence that's been presented here about the health effects of smoking. People here -- the people here who smoke have been through a process of education about the hazards of smoking but they continue to smoke, so education alone doesn't work.

Q- I said leave aside the cigarette and about food, alcohol and things like that. Why people won't change their lifestyle?

A- Oh, people do change their lifestyle, and education is a part of that, but there are many other things that

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influence people to change their lifestyle other than simply education.

Q- Go ahead.

Me POTTER:

Q- I take it, Doctor, that you -- what you're saying is you can get some people to do what you want them to do just by talking to them and explaining to them but there's a lot of people who just won't listen?

A- No, that's not what I'm saying. I didn't say there's a lot of people who just won't listen.

Q- Well, what, they won't obey, they won't do it?

A- It's not a matter of obeying either because no one is ordering them. I think you're putting words into my mouth that I didn't utter. What I'm saying is that knowledge alone is not sufficient to change behaviour.

Q- So in order to change it, you must influence the aspects which are in the outer ranges of the mandala?

A- That's right. To give you an example that is not in the area of tobacco or alcohol or food, you can educate people about wearing seat belts and when you do that, a proportion of the population wear seat belts. However, you get a much greater effect when, in addition to educating people, you introduce legislation that requires them to use seat belts.

Q- Doctor...

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A- For that matter, I mean, one could go on for a very long time, but for that matter you can educate people about the use of fluoridated toothpaste but that choice becomes easier when the companies start to produce fluoridated toothpaste and market it.

Q- I'm going to show you another article which you wrote, Doctor, in nineteen eighty-five (1985), and this is an article entitled "The Mandala of Health", written by you.

A- Yes, I think this one has the more up-to-date version of the mandala...

Q- This has the more up-to-date one.

A- Right.

Q- And in fact it was invented in nineteen eighty-five (1985), wasn't it, the mandala?

A- No, no. The mandala was... actually, I guess we first put it together in about nineteen eighty-one (1981) and started using it in the Department of Public Health in its earlier version in nineteen eighty-one (1981), nineteen eighty-two (1982).

Q- I see. So you used it in nineteen eighty-one (1981) and nineteen eighty-two (1982)...

A- M'hm.

Q- ... but then first published it in nineteen eighty-five (1985)?

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A- I'm not sure when it was first published. It was published first, as I recall, in the -- in Health Education and I don't have that reference with me, unless I have it here.

Q- Well, look at page eighteen (18) of your report.

A- Oh, right. Yes. Okay, yes.

Q- Nineteen eighty-five (1985)?

A- Yes.

Q- So you used it for a couple of years and then offered it to the public in nineteen eighty-five (1985)?

A- It depends on what you mean by offering it to the public. We used it quite widely between nineteen eighty-one (1981) or two ('2) and nineteen eighty-five (1985), when it was first published in the Journal.

Q- You presented it in a published form in nineteen eighty-five (1985).

A- Yes.

Q- Yes. Now, when you presented it in published form in nineteen eighty-five (1985), it was presented that year in the two (2) versions that we have talked about?

A- Yes, I guess so, though I think the -- again, as is often the case in publishing the -- the original version, I guess, was submitted probably even as much as a couple of years before it was first published. I'm not sure exactly when we would have submitted it to

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Health Education.

Q- And you say here that it was -- this is on page two (2) of the article, in the first full paragraph under the heading "The Mandala" -- that it was developed by the Department of Public Health.

A- Yes. I mean, technically speaking, I suppose it's copyrighted, if it's copyrighted at all. That's probably the wrong word. I was working for the Department of Public Health at that time.

Q- When it was developed?

A- Right. It was actually developed by myself and Fran Perkins.

Q- The two (2) people who published the paper in nineteen eighty-five (1985)?

A- That's right.

Q- Yes. And then going on to explain this mandala, you say in the next column, towards the -- the first full paragraph in the next column, you say that:

"This individual ..."

-- we are talking about an individual --

"The individual exists within a family that plays a vital role in establishing health values, attitudes and habits and continuously influences the health of its members."

Later on you say in that paragraph:

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"The family acts as perhaps the most important mediating structure between persons and social institutions."

Do you still believe that today?

A- I think it's certainly one of the most important. I'm -- yes.

Q- Well, you said "perhaps the most important". Do you agree with that today?

A- It's perhaps the most important, yes.

Q- And on the next page, in the first column you talk about four (4) factors affecting the health of individuals. And right away, Doctor, to put you at ease, I'll draw your attention to the paragraph numbered three (3) in which you say:

"Exposure to advertising affects their health."

But we know you're not an expert in advertising, so I'm going to deal with other things. And you say there in number two (2):

"Personal behaviour. All these things affect health."

So you agree that dietary habits affect health?

A- Oh, yes.

Q- And you agree that drinking affects health?

A- Drinking to excess, certainly.

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Q- Yes. General risk taking affects health?

A- That's right.

Q- For instance, hang gliding or mountain climbing affect...

A- Or skiing.

Q- Or skiing...

A- Yes.

Q- ... affects health. And the preventive behaviours that people do or do not take, that affects health too?

A- That's right.

Q- Now, in order to improve people's health via this mandala, would you be aiming at all those personal behaviours?

A- Yes. I mean, you may be targeting a particular behaviour, let us say smoking, but -- so you wouldn't necessarily have -- your program wouldn't necessarily obviously attempt to address all of those problems together.

Q- Well, no, I understand, but...

A- But over time.

Q- ... as a public health...

A- Yes, the public health...

Q- ... strategy you would aim at all those behaviours, would you not?

A- Yes.

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Q- Yes.

A- If you're trying to improve the health of the public, you have to address all of those behaviours.

Q- And in order to address them properly, you must address them via all the aspects of the mandala?

A- Yes.

Q- You cannot do it just by talking to the individual?

A- That's right.

Q- And at page five (5), at the bottom of page five (5), the last paragraph, you write that:

> "It is important to identify and examine the many political issues involved at the various levels of the human ecosystem hierarchy, identified in the mandala, personal and family, community and society culture, if effective action with and on behalf of high risk populations is to be undertaken."

You agree with that today?

A- Yes.

Q- Yes. Okay, so you have to -- you have to get involved in the political issues, if I understand you, at the various levels of the mandala?

A- Yes.

Q- Yes.

A- So that the issue of -- one of the areas of concern, in

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fact, in health promotion today has to do with the notion of empowerment and therefore the issue of power within a system, which is a political issue.

Q- My Lord, may we give this one a number? This will be ITL-36.

Well, I'd like to speak more generally about public health now, Doctor. If you want to refer to the mandala, go ahead, but I'm on a more global level.

And, first of all, if we want to define public health, could you just look at page seventeen (17).

A- M'hm.

Q- And I think on these pages what you're doing is setting out various peoples, different definitions of public health and the missions of public health.

A- That's right.

Q- And you refer to a -- the U.S. Institute of Medicines Committee for the study of the future of public health.

A- Right.

Q- And you quote them, one-third of the way down the page, saying that the common themes that run through these interpretations of public health are reflected in the words "public" and "health."

Doctor, I'd like to ask you to help us out a little bit more. You've said, I think, that the mission is to make as many people as possible as healthy as possible?

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A- That's right.

Q- And you say that there have already been very many successes. In fact you draw our attention to life expectancy, which in Canada has shot up since eighteen thirty-one (1831) and since nineteen twenty-one (1921). You mention that at page ten (10).

A- Yes, right.

Q- And that's a result of public health?

A- Yes.

Q- Yes. And that great increase, because now it's about seventy-five (75) years.

A- Right. Yes.

Q- Life expectancy of fifty-five (55) has gone to seventy-five (75) in the space of sixty (60) years -- sixty (60), seventy (70) years in Canada, using public health.

A- Yes, using public health and as a result of a number of things: public health and broad socio-environmental improvements.

Q- All right. Now, that's a considerable success, don't you agree, Doctor?

A- I think so.

Q- Yes. And it certainly adds to the years people can live and the quality of life they can live; is that not true?

A- That's right.

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Q- And can you think of any public health measure or initiative taken during the past sixty (60) years which included a ban on advertising?

A- I can't particular recall one.

Q- Offhand you can't think of any.

A- There may well have been some, I don't know.

Q- I see. Okay. And you say at page five (5) that public health initiatives are often in conflict with commercial interests.

A- Well, actually let me go back a step, actually.

One ban on advertising that has been in effect, if you like, a voluntary ban, has been, for example, tobacco ads have been refused on the Toronto Transit Commission, on the T.T.C., newspapers have, in effect, banned tobacco advertising or refused to accept it. So that's one example.

Q- Are you saying that those things brought life expectancy up to the seventy-five (75) years it is today?

A- I think those things contribute to an improvement of the public health.

Q- And none of those were legislated bans, were they?

A- No, that's right.

Q- No.

A- I said voluntary.

Q- Yes. And now you say at page five (5) that public

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health initiatives are often in conflict with commercial enterprise?

A- That's right.

Q- Yes. Now, are they not often in conflict with personal interest as well? It's not just the commercial interest which you have to deal with, it's personal or private interests, it's private preferences and individual desires you have to cope with?

A- That's right.

Q- Yes. And those personal desires, those individual preferences, you say none of those can amount to rights, to fundamental rights?

A- What I have argued in my paper here is that -- that rights are not in this sense absolute, that there is a balance. Clearly there are times when public health measures restrict rights, restrict freedoms.

Q- Well, is there any individual right, in your view, Doctor, which is sacrosanct? Which must not be breached, whatever the problem?

A- Yes, I'd say the right to life.

Q- The right to life. So when you say there are no absolute rights, you'd say you have the right to everything -- you have no absolute rights, except to life?

A- Well, clearly to breach the right to life would be to

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breach public health principles.

Q- Well, if you want to speak hypothetically, Doctor, we can imagine a terrible plague sweeping -- a communicative plague.

A- M'hm.

Q- In which the only practical way to stop the spread of the plague is actually to kill the people who have it, to stop them from getting around?

A- I've never heard of any such measure being advocated.

Q- No, I know. It's never been advocated, but I'm trying to find out just what the limit is. If -- what you've written that there is no limit, that no right is absolute. And you're telling me now that you would say: well, perhaps the individual has an absolute right to life. Is that where you stop?

A- I would think so, yes.

Q- Yes. All other rights are...

A- The point...

Q- ...are super...

A- No, I think the point that I'm making here is that rights are balanced and so there is a balance and you can't specify an absolute right when you get into issues of -- particularly when you get into complicated issues of public health. And I suppose, if you wanted to get hypothetical, maybe one could envisage a situation where

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-- where what you hypothesized came true. It's extremely improbable, but I suppose not impossible. We certainly do it for a variety of other animals.

Q- Sure we do it. We kill sick animals, don't we.

A- Yes.

Q- Because we think that stops the spread of disease.

A- But that's not the issue we're arguing here.

Q- Well, I'm asking you: just where does public health stop? How far would you go?

A- I think you go as far as you can go in -- to the extent that society is willing to go, so it gets back to the issue again of social and political acceptability.

Q- I see. So it becomes a question, Doctor, as you've said, you've been open about it in your report, a question of social and political acceptability?

A- That's right.

Q- And the limits on what you can do in playing with people's mandalas is social and political acceptability? There's no other limit, is there?

A- Broadly speaking, that's true.

Q- That's true. And when you talk about political acceptability, do you agree with me, Doctor, that prohibition was politically acceptable. It passed. It was adopted.

A- M'hm.

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Q- So it was politically acceptable.

And you have said in your report that this ban on advertising of tobacco must be politically acceptable, because it passed parliament?

A- That's right.

Q- Right. And when we get to social acceptability, I take it from what you said to Mr. Cherniak yesterday, that what you look at mostly is the polls?

A- Yes, in this connection.

Q- M'hm. And some of the polls which you cite show acceptability of the ad ban hovering around fifty percent (50%), either just above or just below?

A- M'hm.

Q- Right. And that's enough for you to say: let's go. Let's do it!

A- Yes, I think it's enough to say that we have reason to believe that this will be socially acceptable and it's worth trying.

Q- Right. And what happens if the question of social acceptability changes over time, because you admit it does, doesn't it?

A- Yes, it does.

Q- Yes. And what happens if it changes over time? Does that change the limit to which public health is entitled to go?

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A- In practice it does. As social acceptability changes, so what public health can or can't do or...

Q- Right. So legis... in your view legislation which is acceptable today, might be unacceptable next year?

A- Yes. Yes, indeed.

Q- Now, who is it, Doctor, who decides what's socially acceptable? Who should decide that, in your view?

A- I think that's a difficult question to answer because I think social acceptability is a combination of partly whether or not -- partly -- partly from opinion polls, I think, but partly from the extent of public feeling manifested, for example, in protests, in letters, in meetings and so on, and so it's a hard thing to gauge.

Q- Now, this -- this mandala we're talking about...

A- So perhaps I can just go back a little and expand a little on the notion of social acceptability. By reference to the -- again to the bylaws that have been put in place over the years to prohibit smoking in a variety of settings -- and clearly those have been socially acceptable, they have been well accepted and, what is more, the social acceptability has changed over time so that things that would not have been socially acceptable ten (10) or fifteen (15) or twenty (20) years ago are clearly socially acceptable now.

Q- Yes.

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A- On the other hand...

THE COURT:

Q- But that kind of reasoning can lead you directly to the gulag. I mean, when you think of it, you impose a constraint on people and you say there is no revolt, so therefore it's acceptable. They did the same thing in Russia for sixty (60) years.

8/0083 A- Yes, but then we're not living in Russia.

Q- No, but I mean the same reasoning, can it lead exactly to the same situation?

A- But we're living within a democratic society, with a system of courts and parliament and all the rest of it and free...

Q- Oh, they have courts, they have codes. At one time, the Russian Criminal Code was quoted as one of the best in the world. Also they had judges who said that the Code should not be a stone in the -- doit pas être une pierre dans le jugement du juge. On va prendre un ajournement de quinze (15) minutes.

SHORT RECESS

Me POTTER:

Q- Doctor, I'd like to come back to your mandala. I'm sorry if I'm mispronouncing it. It's mandala?

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A- I don't know.

Q- You don't know?

A- Any way that works.

Q- Anyway, that circular symbol of the universe. And those aspects which don't have to do with the individual, which are -- have to do with his environment, you have referred to that from time to time as his ecosystem, have you not?

A- Yes. I mean, one way to think of this whole model, in fact the subtitle is a model of the human ecosystem.

Q- The model of the hu... yes. In fact, there it is at the bottom of the page.

A- Yes.

Q- And that ecosystem, the way in which you use that word, is everything: the climate or the influences surrounding that man, what pushes him to do this thing and that thing?

A- Yes.

Q- Yes.

A- That's the ecological perspective.

Q- Right. Now, I think I'm right, Doctor, in saying that many people compete to have an influence in that ecosystem. The family is out there trying to compete and having an influence on the individual, is that not true?

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A- Yes. I'm not sure they'd necessarily see it as competing.

Q- No, but they're all out there trying to influence that fellow in the middle, aren't they?

A- Not necessarily consciously.

Q- Nevertheless...

A- For example, I mean, a lot of what the family does in terms of its influence, for that matter the community, is not a deliberate attempt to set out and influence. It's a consequence of their existence and the way they function.

Q- On the other hand, that individual is receiving input...

A- Yes.

Q- ... whether it's consciously directed at him or not, from the family...

A- Yes.

Q- ... from his neighborhood, from his girlfriend...

A- Yes.

Q- ... from the television...

A- Yes.

Q- ... from advertisers...

A- Right.

Q- ... from editorialists. There are very many sources of information and of influence and of example...

A- Right.

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Q- ... directed at, consciously or unconsciously, the individual in the middle of your ecosystem, isn't that correct?

A- Yes.

Q- Yes. And I think it's fair to say that the people who are consciously directing messages at the individual, they may have different ideas, may they not, about what is the right way to carry on and what is a good way to run one's life?

A- Oh, I'm sure they do.

Q- Yes. So what is coming at that individual is a whole panoply of different ideas, some of them conflicting the ones with the others?

A- Yes.

Q- Yes. And that is the ecosystem that you say public health must influence?

A- Yes.

Q- Right. This is another article which you wrote, Doctor, in nineteen eighty-two (1982), and this is an article entitled "Education of the Medical Officer of Health in Canada," and you wrote it with two (2) gentlemen called Best and Le Riche. Do you still work with them?

A- No, they're both retired now.

Q- They're both retired. Now, though you had not published your mandala of health in nineteen eighty-two (1982),

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you were by then using it?

A- Yes, I think so.

Q- That's right.

A- Around then.

Q- Around then. And the idea of wanting to influence the various aspects of a mandala was an idea which you already had by nineteen eighty-two (1982), wasn't it?

A- Yes, I think it was there.

Q- And if we look at the very last paragraph of this article, Doctor, in fact the last sentence before the acknowledgement, we read that:

> "The specialty of community medicine may recapture the prestige in which it was once held by providing leadership in improving and controlling the ecosystems in which man himself operates in order to improve the community's health."

Now, Doctor, I want to put it to you very directly. Is your view of things that public health imperatives should control the ecosystem?

A- I think they're one of the factors that are involved in controlling the ecosystem, certainly. I mean, that's part of what public health attempts to do.

Q- You think public health initiatives should be aimed at controlling that ecosystem?

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A- To the extent that it makes sense, yes.

Q- Well, what does that mean, to the extent that it makes sense?

A- Well, it depends partly on what the subject matter under discussion is and what it is one's trying to achieve and what level of the ecosystem. I mean, it's...

Q- And part of that control of the ecosystem is to reduce or even get rid of the pressures and influences which are directed at that individual which you would consider nefarious?

A- The purpose of attempting to influence and control the ecosystem is an attempt to improve the health of the population.

Q- Yes, I understand that, Doctor...

A- Yes.

Q- ... but you said before that you want to control that ecosystem because one of your goals is to reduce or eliminate the pressures on the individual which you consider lead him in the wrong direction, isn't that true?

A- I'm not quite sure what it is you're driving at in the sense of controlling.

Q- Well, you use the word "control", Doctor, in that article.

A- Yes. Well, let me give you an example: one way of

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controlling ecosystem is to build sewage plants, and what that does is to control sewage contamination. So the notion of controlling the ecosystem, again as many other things in public health, is a very multi-faceted complex concept. It's not a simple matter of let's control, in a dictatorial sense. It's control in the sense of, as I say, they influence and control, actually improve and control.

Q- On the other hand...

A- So how do you influence the ecosystem.

Q- You agree with me that some of those pressures that I'm talking about, which come down to the middle of the mandala on to the individual are pressures which you consider lead him in the wrong direction. You agreed with that before the coffee.

A- Oh yes.

Q- Yes. And do you agree with me that part of the public health mission is to get rid of those pressures to the extent feasible?

A- Yes, it's to try and remove influences in the environment which tend to lead people into health harmful behaviours, if you like.

Q- Into making a wrong decision about how to carry on his life.

A- No, not into making a wrong decision in that sense but

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into making decisions that are not necessarily in the best interests of their health. So what we are attempting to do is to encourage people to make decisions that improve their health.

Q- And one of the ways...

A- And in fact one of the... if you look for example at one of the central concepts of healthy public policy, it is that what we are attempting to do through healthy public policy is to make healthy choices the easy choices.

Q- And one of the ways you're going to get him to make the decision which you consider best for him is to reduce the strength or even the presence of the pressures which you consider unhealthy?

A- To the extent that's possible, yes.

Q- Now, what happened to the idea, Doctor, that I should have a right to decide myself to what pressures I will be exposed? Do you agree that I have that right? What if I'd like to be exposed to a pressure you don't like?

A- I think you've got the right to choose what pressures you want to be -- well, it's -- I mean, that's really a rather spurious question, I think, because I don't think that people choose the influences to which they'll be exposed.

Q- Well, I do.

A- Well, I don't at all. I disagree with you.

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Q- Now, you call yourself a health futurist, Doctor. Let's look down in the future a little bit and let's use the ideas that you've put on the table and see what might happen?

A- M'hm.

Q- You've -- you've said at page twenty (20) of your report in relation to fat and coronary deaths, top of page twenty (20), My Lord.

THE COURT:

Have you given...

Me POTTER:

Oh, I'm sorry, My Lord, no we didn't give it a number.

BY THE CLERK:

ITL-37.

Me POTTER:

Thank you. ITL-37.

THE COURT:

You have so few, don't miss any.

Me MITCHELL:

He has sixty (60) in one (1).

Me POTTER:

Mr. Mitchell quite correctly points out that I've cheated and put a good sixty (60) exhibits in one (1) binder with one (1) number. Nevertheless, I still don't come up to the RJR volume.

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THE COURT:

Page twenty (20) of the report?

Me POTTER:

Page twenty (20) of the report, My Lord.

Q- And here, Doctor, we're talking -- you're talking about fat -- fat levels and coronary deaths, and you say in the bottom of that first paragraph that:

"85% of excess coronary deaths come from people whose blood fat levels are either in normal to high or in high risk range."

Is that right?

A- If you put those two (2) together, yes.

Q- That's correct. So eighty-five percent (85%) of coronary deaths come from people who present a risk factor fat level in the blood, isn't that right?

A- I'm sorry, I was reading that and not listening to you. Could you repeat that?

Q- Eighty-five percent (85%) of coronary deaths, excess coronary deaths, come from people who present the risk factor of fat in the blood?

A- No, eighty-five percent (85%) of the deaths come from people whose blood fat levels are in the normal to high and into the high risk group.

Q- All right, and what you say...

A- And actually -- actually, I'd have to go back and check

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whether they were -- whether the seventy-five percent (75%) includes the ten percent (10%) or not.

Q- All right. So it's either seventy-five (75)...

A- So it's seventy-five (75) to...

Q- ...to eighty-five (85)?

A- Yes.

Q- All right. Now, I think I'm right, Doctor, in saying that diet is the principal reason for which fat gets into the blood?

A- Yes.

Q- Right. So these people are in the normal to high or in the high risk range because of their diet?

A- Correct.

Q- Right. And I think what you say is that it's a -- in order to help those people, you could only achieve a certain success by talking directly to them. You can get a much greater success by playing with their mandalas?

A- Well, I think you have to understand that -- first of all, I don't like this term playing with their mandalas, it's...

Q- It's pejorative, isn't it?

A- Yes, I'd say so.

Q- Yes, it's meant to be.

A- Yes, I'm sure it is -- if "pejoration" interests you.

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But -- I'm not even sure that "pejoration" is an English word. But setting aside the issue of whether or not we're playing with their mandalas, as you care to put it, certainly what you want to do with people with respect to their diet is to both educate them and to the extent possible influence their diet in any way that's, again, I would go back to it, socially and politically acceptable.

Q- Right. So, what you want to do is bring influences to bear on -- on those individuals by influencing the aspects which are on the outer edges of the mandala?

A- Both the outer and the inner.

Q- Both of them.

A- I mean, it is, again, a classical public health approach that we're talking about here, where you imply a multi-faceted strategy all the way from the individual to the societal level.

Q- Right, but you're going to get more of an effect if you also -- I'm not saying only, but if you also play with those aspects in the outer edges of the mandala?

A- Yes.

Q- Yes.

A- You likely will.

Q- You likely will, and do you agree with me that the social acceptability of very fatty foods is going down?

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A- Yes.

Q- Yes, and in the end, do you think you might be able to get the results you want, reducing those people's risks and, in fact, improving their health -- improving the community's health, lowering the number of excess coronary heart deaths by one day banning the advertising of fatty foods?

A- Well...

Q- What's to stop you?

A- That's a hypothetical question.

Q- Yes.

A- I'm not sure that I'm going to give a hypothetical answer. I think that, at this point, what is clear is that we can influence people's food choices through education. We can also work with restaurants, for example, food chains and so on, food producers for that matter, farmers for that matter, to have them produce lower fat food so that what you're doing is you're -- you're reacting to a social change and changing the market at the same time.

Q- Well, Doctor, I'm going to put the hypothetical question to you. If the social acceptability allowed for it, would you ban the advertising of fatty foods?

A- I don't think it's a question I've really come to yet because I don't see it as a socially or politically

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acceptable strategy at this point.

Q- Right. And I'm telling -- putting in the hypothesis if it were socially acceptable, if that one (1) obstacle were removed, if that one (1) requirement that you referred to before were met, would you be advocating banning the advertising of fatty foods?

A- Well, I'm not at that point yet so I'm really not in a position to answer that.

Q- No. And would you ever go to the point of imposing menu requirements on restaurants?

A- I doubt it. I think that we've been able to achieve change through -- through education and through working with social forces and so on. So I think that's not very likely.

Q- And what about red meat? Do you agree that red meat is a risk factor?

A- Red meat is a rather general term. I think fatty meat is a risk factor.

Q- You refer at page twenty-five (25) of your report to empty calorie foods.

THE COURT:

Page?

Me POTTER:

Q- Twenty-five (25). I'm very sorry. You refer to Professor Leon Eisenberg, who he refers to empty calorie

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foods.

A- M'hm.

Q- And he says that advertising is used deliberately to induce the purchase of such things as empty calorie foods?

A- Yes.

Q- Can you see the time coming, as a health futurist, Doctor, when it would be required to ban the advertising of empty calorie foods?

A- I suppose it might at some point, but I don't think that's a question at this point and I don't think that we're talking about -- we're talking about a hypothetical situation. It's very hard to say what will happen.

Q- Driving fast is a risk factor; isn't it? It's a danger to health?

A- Yes.

Q- It is.

A- That's why we have speed limits.

Q- That's why we have speed limits.

A- In part.

Q- Right. And have you seen advertisements of cars driving very fast?

A- Yes.

Q- Yes.

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A- Now, whether they're breaking the speed limit, I don't know.

Q- You don't know. But do you think inducements to drive fast should be removed from society?

A- Yes.

Q- Yes. So if movies which show car chases and speeding cars down the highway, do you think we should play with the movies and try to eliminate scenes like that?

A- I think there's a number of areas like that where it would be better if those things weren't shown.

Q- Right.

A- Now, whether or not one can actually go out and ban it is another matter, because it comes down to a matter of, again, whether it's socially and politically acceptable. I think the whole point here is that it would appear to be socially and politically acceptable to ban tobacco advertising. I doubt whether at this point it would be socially and politically acceptable to ban advertising for fast cars or to ban advertising for what Professor Eisenberg calls empty calorie foods.

Q- Yes. What do you understand him to mean by empty calorie foods?

A- Oh, I would think he's referring to things like, I don't know, Coca Cola and so-called junk foods. I don't know exactly what he means, but I would put it in that

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general category.

Q- But the kind of foods we all go in to buy at the corner store for a snack?

A- Absolutely.

Q- Yes.

A- Absolutely.

Q- Yes. Now, Doctor, I put it to you that you don't really like advertising in general. You consider advertising to be mind-numbing and you'd just as soon see less of it?

A- I think that advertising may have a place, but I think that a lot of advertising is a problem.

Q- A lot of advertising is a problem. Not just of cigarettes, but lots of advertising?

A- Yes, I think that's fair.

Q- Yes. Because you consider it mind-numbing.

A- I assume you're quoting me?

Q- I am. It's in RJR-173 at page three twenty-one (321). Do you consider it mind-numbing?

A- Yes, if I said that.

Q- Yes.

THE COURT:

Page one...

Me POTTER:

Page three twenty-one (321), My Lord, in the top

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right-hand paragraph.

THE COURT:

173. Which...

Me POTTER:

It's seven (7) and eight (8) lines down from the top, My Lord.

THE COURT:

Of what?

Me POTTER:

Sorry, page three twenty-one (321), right-hand column.

THE COURT:

Right.

Me POTTER:

Q- That's in the paragraph where you seem to be advocating the conserver...

A- I'd better see where that is.

Q- It's right here, Doctor.

A- Right.

Q- So that's part of the conserver society, that right brain, feminine society that you advocate and you would see that as giving us less mind-numbing advertising, is that correct?

A- Yes, I assume again you're using right brain and feminine as pejorative terms.

Q- No, I'm using your terms, Doctor. That's how you

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described it.

A- Yes.

Q- Right.

A- However, your tone leads me to believe that.

Q- Yes. Doctor, you ran for office, didn't you one day?

A- Yes, I did.

Q- All right. Thank you.

THE COURT:

Yes, Mr. Mitchell.

CROSS-EXAMINATION BY Me DOUGLAS MITCHELL

on behalf of Petitioner, RJR-Macdonald Inc.

Q- Dr. Hancock, you mentioned yesterday that you used to smoke?

A- Yes, I did.

Q- Did you enjoy it?

A- Yes and no.

Q- I asked because you mentioned a whole bunch of factors why people continue to smoke and you didn't mention the fact that they enjoy it. But you can conceive of a fact that they might enjoy it?

A- Oh, yes. I think so. Though I think also, if you talk to a lot of smokers, they in fact don't enjoy it and would like to give it up.

Q- But there are a great number of smokers out there and --

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that although they know that perhaps they might improve their health by reducing their smoking, they choose not to, because they enjoy it; right?

A- I assume so, yes.

Q- Yes. So we can -- we can conceive of that. So they're not -- individuals aren't total victims?

A- No, I've never suggested they're total victims.

Q- No. Well, when we talk about the Lalonde report.

A- Yes.

Q- In nineteen seventy-five (1975), I believe you called that the "blaming the victim theory"?

A- No, I didn't say that. The Lalonde report itself is a blaming the victim theory. I said that...

Q- That's what it came to be known as; right?

A- What -- the Lalonde report? No, not at all. What I was saying was that the Lalonde report raised the issue of environment and lifestyle and that the early emphasis came to be upon the lifestyle side.

Q- Well, if we turn to page twelve (12) of your report.

A- Yes.

Q- You're talking about the health of Canadians, more commonly referred to as the Lalonde report. The report stressed, and I'm quoting:

> "Future improvements in the level of health of Canadians lie mainly in improving the

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environment, moderating self-imposed risks and adding to our knowledge of human biology."

And you go on at the bottom, the next paragraph, to say:

"The message was clear. The health of Canadians would be greatly improved if they would only make changes in their self-imposed risks and behaviour."

A- Yes. And that is the message with respect to lifestyle, but that was not the entire message of the whole report.

Q- Then you said: "this approach became known as victim blaming."

A- That's right.

Q- Now, I'm just wondering, when you say "victim," how is a person defined as a victim? What qualifies him as a victim?

A- The notion of victim blaming is the notion that people behave in ways for a variety of reasons to some extent, as I've said before, people don't simply choose an individual behaviour, that choice is influenced by a variety of other forces, social forces, environmental forces, family influence and so on. And that, therefore, they are inadvertently the victims of their situation. And to give you a good example, a number of children grow up in poverty. There are certain behaviours and certain consequences of growing up in

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poverty that are very bad for one's health. They are therefore, since they didn't choose to be born into poverty, they are the victims of poverty. And to simply turn around and then, if you like, accuse them of behaving in ways that harm their health, is to fail to recognize that they are the victims of their circumstance and therefore is blaming the victim for something for which they're not responsible. That's what victim blaming is about.

Q- But a victim is everyone in society then? Everyone is a victim?

A- To some extent. I mean some people are more victims of their circumstance than others, I think. Some people are more influenced and mortified than others for a variety of reasons. They may be, for example, to take a hard case of poverty, children who are born into poverty are more the victims of poverty than children who are not born into poverty.

Q- And victims of advertising. If somebody's a victim of advertising, are you saying that, for example, let's deal with cigarette advertising. Are you saying that cigarette advertising makes it just too easy to choose to smoke?

A- Yes.

Q- Makes the choice easier -- and that's the mind-numbing

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advertising that you're talking about?

A- That's right. What cigarette advertising does is it is part of the overall influence that is out there in the environment. In the case of cigarette advertising it usually makes smoking appear to be a socially desirable thing. It's linked to success. In a variety of ways it helps to create an environment in which people are encouraged to see smoking, firstly, as an acceptable behaviour and secondly, as a desirable behaviour.

Q- But you described it as mind-numbing and that was what I was interested in.

A- M'hm.

Q- Now, you earlier said that the goal of public health is to make healthy choices the easy choices?

A- That's the goal of healthy public policy.

Q- Right. Right. Sorry.

Now, I'm just interested, what's the difference -- is the only difference because you, as a public health officer, view this as beneficial? That it's not mind-numbing for some reason?

A- What is not mind-numbing?

Q- Your view, making -- altering the environment so that the healthy choices are the easy choices?

A- No, what I'm talking about is that in attempting to make healthy choices the easy choices, there's a variety of

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ways you can go about doing that, but if you look at the whole notion of health promotion, of which healthy public policy is one strategy, the whole point is, in fact, a definition of health promotion, is to enable people to increase control over and improve their health. I don't see that as mind-numbing. Quite the reverse.

Q- Well, I'm having trouble. If advertising makes it easier for you to choose cigarettes and public health makes it easier for you to choose the -- what you view as the healthy benefit, what is the philosophical difference?

A- The philosophical difference is that on the one hand, through a ban on advertising, for example, we are seeking to remove an influence that makes smoking a desirable activity and then through a variety of strategies, such as working with children particularly, in fact a lot of our emphasis in public health and smoking has been on children, working with children to help them to learn to say no. So the whole focus of the notion of a generation of non-smokers and things like that is to help, particularly to help children to make the choice not to smoke. And that is very different from simply a propagandistic approach to get them to say no. So, it's a matter of helping them, empowering them,

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if you like, to make that choice.

Q- So advertising isn't mind-numbing because it makes the choice easier? It makes the choice to smoke easier. It's mind-numbing because it's advertising cigarettes, or because it's advertising? I...

A- I think what I was getting at with the notion of mind-numbing is that advertising is, if you like, a passive process of transferring information. It is not a -- it does not actively involve people in looking at their situation and making that choice. So it's an attempt to...

Q- You mean it acts on the environment. It doesn't act directly on the individual?

A- Oh, I think it acts directly on the individual too.

Q- Which is as opposed to the mandala which works on the environment and on the individual as well?

A- The mandala is a model that helps one understand what it is that influences health. So I don't quite see the point of your question.

Q- Okay. The point of my question is: you're saying advertising is a pressure?

A- Yes.

Q- Now, by removing that pressure and substituting it for your view, are you not replacing one pressure within that mandala with another that you, Trevor Hancock,

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happen to believe is the better one?

A- No, it's not a matter of what I, Trevor Hancock, happen to believe. The point of this whole exercise is that we know that tobacco smoking is a major cause of death and disease. It's been called the major -- number one (1) preventable health problem we face, and so on. And so what we are attempting to do in a broad and multi-faceted way is to reduce tobacco smoking. The goal, obviously, is to seek to reduce and prevent death and disease caused by smoking.

Q- What about alcohol? What if I told you the Canadian government...

A- What about alcohol?

Q- ...government found in nineteen seventy-seven (1977) that if you measure death, premature death as potential years of life lost, alcohol was a greater cause of death than smoking?

A- Yes.

Q- Can you accept that?

A- I've seen data to that effect. I'd be happy to see some more if you have it.

Q- We have it somewhere, but as long as you accept it, I mean that's fine.

A- Well, I didn't say I accepted it. I said I'd be happy to see it.

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Q- Take it as a hypothetical, and it's been introduced as evidence here.

A- I assume so. I haven't seen it.

Q- Would you favour banning alcohol? I mean are you working as the ...

A- No.

Q- ...the unreasonable man that you were talking about yesterday, are you working to bending the environment to banning alcohol as well?

A- I think you are somewhat taking the quotation of the unreasonable man out of context. What that quotation was about is that, if you like, the reasonable man accepts the way the world is. If we were to do that, we would simply accept that people smoke and people will die and there's an end to it. That's not...

Q- No, I didn't mean it pejoratively. I did not mean it pejoratively. The unreasonable man bending the environment I recognize, you know. I think that is the way -- the context in which it was used.

Now, why not alcohol?

A- I think alcohol, but the issue is more complex. It's more complex because essentially the message around smoking is a fairly simple one: don't smoke. The message around alcohol is a more complex one, because we know that you can consume alcohol at a modest level and

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it doesn't harm your health. In fact there's even been some studies that suggest that a moderate level of alcohol contributes to ill health. So the message is a more complicated, a more sophisticated message, and therefore, I think the strategies you use would be different, so that it is, to go back to the issue that was raised earlier about what advertising you would and wouldn't ban, I think it depends upon the subject under discussion and again, to go back to it, the social and political acceptability. But I think in the case of alcohol, the problem is that the message is a sophisticated message of drink -- drinking is okay as long as you do it in moderation, and that's a very different message. And therefore...

Q- But a lot of people don't.

A- Well, a lot of people don't, I agree. And a lot of people don't drive their cars safely either. And a lot of people eat fatty foods.

Q- I'm just -- I just -- one final question or series of questions.

You -- Mr. Evraire asked you yesterday several times or twice if you need to know that the policy is going to work, you remember he was discussing advertising, a ban on advertising. Do you need to know, as a public health officer, that it is going to work.

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A- M'hm.

Q- And I think you basically said: no, we have -- what you said -- used -- you fell back on the terms of the law, the reasonable and probable grounds.

A- M'hm.

Q- But in the context of public health do you believe -- you quote Professor Knox and you say: right loses its quality as being fundamental and becomes a desirable state of affairs. It still is a highly desirable...

A- Let me just find that quote.

Q- I believe it's on page twenty-four (24).

A- Right. The quote is...

Q- It's the second part of the quote that I'm interested in. I'm just wondering how desirable is it from a public health point of view? Is it highly desirable to protect the rights?

A- How desirable is what?

Q- Is protecting the rights or the notion of a right?

A- Oh, I think that public health is concerned with protecting the rights both of the individual and of the collective and that a lot of the debate that goes on is -- revolves around to what extent should one restrict rights of the individual to protect the group as a whole. That's a common debate in public health.

Q- But...

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A- For example, should you quarantine AIDS cases.

Q- Should we have leper colonies?

A- Should we have? Yes, right, should we have leper colonies.

Q- Is that a good public health decision?

A- Well, I think in the context of its time it may well have been. It's really not necessary now, although in fact, as I understand it, some people with severe and disfiguring leprosy prefer to live in that kind of an environment because it's -- they're with people who have the same problems. But generally, I mean, leper colonies hardly exist anymore. So as...

Q- Anyway to get back to my...

A- ...well, as social -- but what happened there is a combination of things. As social values changed, as technology and science advanced and so on, we were able to make those changes, so there's now a treatment for leprosy that didn't exist. The same with sanitoria for tuberculosis and so on. Generally speaking, we don't put people in sanitoria any longer.

Q- Anyway, to get back to my original question: how desirable is this notion of a right. And I'm just wondering, our constitution says it's a fundamental right and I just wonder sort of where you fit in with the constitution?

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A- The constitution says what is a fundamental right?

Q- For example, the right of free speech?

A- I don't know what the constitution says specifically on that.

Q- Take it from me that it does. I mean, take it as a hypothetical.

A- Well, as I understood it, the constitution said that something is -- I'm not a lawyer, but as I understand it, there's something called a notwithstanding clause that enables governments to supercede those rights that are in the constitution.

Q- Anyway...

A- So they're not absolute it seems to me. The constitution implies...

Q- Anyway, just how desirable is it? I'm just -- generally is it highly desirable, merely desirable?

A- To do what?

Q- This notion of right. This thing that you quote here:

> "...notion of a right begins to lose its commonly attached attributes as being fundamental or inviolable or absolute. It becomes simply a desirable state of affairs."

A- Right.

Q- Now, how desirable?

A- Well, I guess that depends on the topic under discussion

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and it depends on the right you're talking about.

Q- Okay. Okay, now...

A- These things are very complicated.

Q- In the context of a public health adviser, I'm going to ask you to assume that you are advising the Canadian government on whether to pass this law. Now, you said Mr. Collishaw sent you the New Zealand Toxic Substances Board Report, right?

A- Yes. Of course, they've already passed this law.

Q- That's right. That's right. Before that, did he send you anything else?

A- Not that I'm...

Q- That would show the Canadian government's evaluation of the effect of a ban on advertising?

A- Not that I can recall.

Q- So I'll have to ask you to assume that they came to the conclusion that there was no definite evidence one way or the other.

A- I don't know that, but I'll take...

Q- I'm just asking you to accept that.

A- I'll take your word for it.

Q- And I'm also -- do you know that there has been a ban in Norway and Finland, a ban on advertising in Norway and Finland for many years?

A- So I understand.

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Q- And if I told you, as a public health adviser, that the -- in the countries such as Canada, Britain, the United States, the decline in smoking rates have been far greater over the past ten (10) years than the declines in Norway and Finland.

A- M'hm.

Q- Would you still recommend the advertising ban?

A- Well, there's a whole bunch of questions that that statement brings up that would have to be answered first, including such things as what have been going on with prices there, what other programs were in place. We know, for example, that price is an important determinant, so you'd need to look at all of those factors. But given a look at all of those factors, I still think that if there's even some grounds to believe that a ban on tobacco advertising might work, then given the seriousness of the problem we're dealing with, it's worth doing it. It's also worth doing it because, as I've also said, it is part of a comprehensive approach to making smoking more socially unacceptable.

Q- So it's worth it because it's smoking?

A- Yes, in this instance.

Q- Thank you. No further questions.

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RE-EXAMINATION BY Me PAUL EVRAIRE,

On behalf of Respondent:

Q- Dr. Hancock, is it your view that the Tobacco Products Control Act is a public health measure?

A- Yes, very much so.

Q- My friends have talked to you about the decision making process, they've looked at the mandala of health and so forth. Let me ask you about a question they didn't raise with you and that's the accountability of public health officials. My friend has put before you ITL-37 on the education of the medical officer of health in Canada. It talks about...

A- Right.

Q- ... the obligations of the medical officer of health. What constraints, if any, exist on a medical officer of health going off on his own doing all sorts of silly things, for example? Are there any constraints that exist on his public office?

A- Oh, there's a number of constraints. There are constraints -- first of all, there are legal constraints. I mean, if you were to take the Health Protection Promotion Act with respect to venereal diseases, I can order you to, if you have a venereal disease, to put yourself under the care of a physician and be treated. You may accept that order and go and do

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it, which clearly implies I have a lot of power.

13/0047 Q- M'hm.

A- But if you refuse, then my next option as a medical officer of health is to go to the Courts and ask for a Court Order. In order words, I can't do anything further. I'm constrained in my further action by the requirements to go to the Courts, so there are legal constraints. There are political constraints, because I am politically accountable to a minister or to a Board of Health in Toronto, for example, and if I do something that the Board of Health considers undesirable, then they may order me to reverse that. That can get you into some interesting arguments because there's a kind of a split jurisdiction, but clearly you can be removed from your position. The minister of health can order you to do things too and can remove you. So there's a whole bunch of constraints.

Q- To remove you from what?

A- From your position. You could be fired. So there are a lot of constraints over what you can do and clearly you only do what seems socially and politically acceptable.

Q- Thank you. Those are all my questions.

THE COURT:

Q- Did you say, in response to Mr. Mitchell's questions, that -- about the ban in Norway and Finland, have you

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studied that ban on tobacco advertising prior to your report?

A- No, not specifically. I have read, as I commented, the Toxic Substances Board report which touched on that.

Q- Thank you.

THE COURT:

Can we free the doctor?

Me EVRAIRE:

Yes, please.

THE COURT:

Q- Okay. You're free to go.

A- Thank you very much.

AND FURTHER DEPONENT SAITH NOT

THE COURT:

I presume that Dr. Turcotte will be this afternoon, I gather?

Me EVRAIRE:

Yes.

LA COUR:

Ah, c'est vous? Excusez-moi.

Me EVRAIRE:

Vous vous demandiez?

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LA COUR:

Hein?

Me EVRAIRE:

Vous vous demandiez, il y a quelques semaines qui était ce bonhomme.

LA COUR:

À moins que vous préfériez commencer tout de suite? J'ai pas de problèmes avec ça.

Me EVRAIRE:

C'est maître Joyal.

Me JOYAL:

Je peux commencer, Votre Seigneurie.

LA COUR:

On pourrait peut-être faire le curriculum vitae ou une partie.

Me JOYAL:

Oui.

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L'an mil neuf cent quatre-vingt-dix (1990),
ce vingtième (20e) jour de mars,
A COMPARU:

FERNAND TURCOTTE, âgé de quarante-huit (48) ans, domicilié au huit quatre-vingt-trois (883) Chanoine-Scott, Ste-Foy, province de Québec,

LEQUEL, étant dûment assermenté sur les saints Évangiles, dépose et dit ce qui suit:

Me JOYAL:

Votre Seigneurie, je vous ai remis, je pense que c'est vendredi, deux (2) curriculum vitae. Ce matin, j'ai l'intention de travailler avec le document qui est broché et non pas le document qui est relié. Le document broché qui était à l'intérieur du c.v. que je vous ai remis...

LA COUR:

Ah.

Me JOYAL:

... est celui qui est à date. Je vous suggérerais aussi d'ouvrir le rapport du docteur Turcotte à la première page, "Introduction", parce qu'il y rajoute des éléments de son c.v. qui ne sont pas mentionnés dans le document

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broché.

14/0052 INTERROGÉ PAR Me CLAUDE JOYAL,

pour l'intimé:

Q- Est-ce que vous avez votre rapport, docteur Turcotte?

R- Oui.

Q- Oui? Depuis quelques semaines, j'ai l'impression de suivre un cours de médecine, alors j'ai l'impression que ça va peut-être se terminer au cours des prochains jours, docteur Turcotte. Je constate à votre curriculum vitae broché, à la première page, que vous avez obtenu votre m.d. à l'Université de Montréal en mil neuf cent soixante-six (1966).

R- C'est exact.

Q- Ça c'est le diplôme de médecine?

R- C'est ça.

Q- Pourriez-vous expliquer à la Cour ce que vous avez fait de mil neuf cent soixante-six (1966) à mil neuf cent soixante et onze (1971)?

R- À la fin de mon internat, Votre Seigneurie, j'ai servi comme médecin dans les Forces armées du Canada. C'était les Forces armées qui avaient payé mes études médicales et j'avais en contrepartie à servir comme officier médical pendant trois (3) ans, pendant lesquels j'ai agi comme d'abord médecin d'un régiment d'artillerie pour à peu près sept (7) mois, et après ça médecin-chef d'une

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clinique de famille, les familles accompagnant les soldats qui étaient à l'époque avec la 4e armée... enfin le 4e groupe de brigade de l'infanterie intégré à l'Armée britannique du Rhin dans le nord de l'Allemagne.

Q- Et je constate à votre c.v. qu'en mil neuf cent soixante et onze (1971), vous avez obtenu un M.P.H. du Harvard University. Pourriez-vous nous expliquer qu'est-ce qu'un M.P.H.?

R- Le M.P.H., c'est le sigle qui désigne... enfin qui signifie "Master of Public Health". C'est un diplôme régulier de deuxième cycle d'université, qui était -- enfin, et reste -- la principale qualification qui est requise pour apprendre la spécialité médicale de la Santé publique, et qui est composé essentiellement, selon les universités, d'un programmes de cours avec ou sans stages pratiques.

Dans le cas du programme du "Harvard School of Public Health", c'était un programme de cours exclusivement, composé de soixante (60) crédits de cours dans lesquels... parmi lesquels on retrouvait essentiellement trois (3) grands groupes de cours: D'abord des cours de méthode -- essentiellement des cours d'épidémiologie, de biostatistique, d'informatique et de recherche opérationnelle.

Deuxièmement, des cours de... des cours de ce que

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les Américains couvrent du terme général de "behavioural sciences", mais qui sont essentiellement des cours de sciences sociales à l'appui de l'intervention sur la santé d'êtres humains. Alors ça comprend la sociologie de l'institution sanitaire; anthropologie de la santé et des maladies; sociologie de la santé; économie de la santé; et politique de la santé, mais politique au sens de sciences politiques des programmes de santé, qui composent à peu près... qui accaparent à peu près le tiers du programme, je dois dire.

Un tiers c'est méthode; un tiers sur les sciences sociales requises pour la mise en place de programmes de santé. Et le dernier tiers enfin, les cours portaient sur essentiellement des champs d'application; des cours d'application; un programme de contrôle des maladies infectieuses, par exemple; programme de protection maternelle et infantile; programme de protection de la santé en milieu de travail; protection... reproduction humaine et démographie; hygiène et sanitation, compris évidemment décrivant toutes les mesures qui relèvent aujourd'hui du génie sanitaire, par exemple; méthode et principes du dépistage, qui sont le vocable sous lequel on retrouve le gros des méthodes utilisées pour l'intervention sur les maladies chroniques, par opposition aux maladies infectieuses; et finalement

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toxicologie environnementale, qui est encore une rubrique générale qui sert précisément à former les experts en santé publique à la reconnaissance et puis à l'intervention sur des problèmes de contamination environnementale, mais contamination avec des produits toxiques plutôt qu'avec des produits biologiques, comme on le fait dans le cadre des maladies infectieuses.

Q- Pourriez-vous nous illustrer ce que peut comprendre un cours "politique de santé"?

R- Dans un cours de politique de santé, essentiellement on essaie de systématiser la façon de procéder d'un professionnel de santé publique quand il s'agit, par exemple, de mettre en place un programme de santé. Il y a, d'une part, tout ce qui concerne l'examen critique de la validité des preuves qui existent à l'appui de la justification d'une intervention donnée, par exemple; et d'autre part l'identification de toutes les activités qui sont requises pour atteindre l'objectif; et finalement l'identification, troisièmement, des différentes possibilités stratégiques de mettre en place le programme.

Alors ça implique, ce genre d'enseignement-là, l'intégration autour de problèmes concrets, de connaissances qui viennent de la biologie, qui viennent de l'épidémiologie mais qui viennent aussi de

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l'anthropologie, et de la psychologie parfois, de l'organisation sociale dans un certain nombre de contextes.

Q- Est-ce que vous pourriez nous donner un exemple qui vous aurait été enseigné dans le cadre de ce cours-là?

R- Oui, il y a plusieurs exemples. Si, par exemple, on essaie de réduire la mortalité infantile dans une population donnée, on peut y arriver en agissant sur différents facteurs. On peut viser d'abord l'amélioration avec la nutrition des mères pendant leur grossesse, mais ça, ça se fait pas dans le vide. Dans certaines cultures, par exemple, où ce problème-là est important, il y a un interdit religieux qui empêche les femmes de consommer des produits laitiers et des oeufs pendant leurs menstruations.

Or, comme la menstruation c'est un phénomène très intime, à toutes fins pratiques ça veut dire que les femmes n'ont pas accès à ces sources alimentaires-là. Donc, dans un contexte où on veut réduire la mortalité maternelle en améliorant l'état nutritionnel, bien c'est une voie qui nous est interdite parce que socialement inacceptable. À ce moment-là, faut trouver des façons, si vous voulez, indirectes d'obtenir le même résultat sans créer, ou en faisant l'économie d'une bataille ou d'un ébranlement de l'édifice culturel de cette

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société-là.

Dans la même continuité, et d'une deuxième façon, sur le même problème d'améliorer la santé des femmes, c'est d'espacer les naissances.

LA COUR:

Q- C'est de quoi?

R- Espacer les naissances.

Q- Ah, espacer.

R- Éviter que les femmes soient enceintes à temps plein...

Q- J'avais compris de se passer... Ça, c'était efficace, pour la naissance des petits.

R- Bien, dans la mesure du possible, si on peut éviter que les femmes soient enceintes à temps plein, de leur puberté jusqu'à leur ménopause, on améliore sensiblement la méthode de santé puisque le coût physiologique d'une grossesse est important, et il est important que l'organisme de la femme puisse récupérer. Mais dans bien des cas, les pratiques qui sont requises pour espacer les naissances sont à toutes fins pratiques... pas présentables, ou pas acceptables, ou pas vraiment introduisables d'une manière efficace dans la société, soit parce que la fécondité est vue d'abord comme une espèce de... comment je pourrais dire?... d'état de grâce métaphysique qui est activement recherché par les femmes; et dans ce contexte-là, bien il est pas sûr que

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le bénéfice net qui est recherché en termes de santé soit commensurable avec le désordre qu'on est susceptible d'introduire dans la culture de ces gens-là. Toujours dans le domaine de la protection maternelle et infantile, je vous ai parlé de la volonté habituelle qui est poursuivie en santé publique ,de réduire la mortalité infantile pour commencer... la mortalité maternelle. Puis le deuxième objectif, c'est de réduire la mortalité infantile. On sait que dans certaines sociétés -- dans toutes les sociétés, de fait, (si on recule suffisamment dans le temps) -- une bonne partie de la mortalité était explicable essentiellement par l'infanticide, et c'est un infanticide qui s'appliquait surtout aux enfants de sexe féminin.

La première... la première... la première solution, ou la première manière d'intervenir, ce serait de précisément essayer de mieux comprendre le mécanisme qui fait, par exemple, peser plus lourdement l'infanticide sur les enfants de sexe féminin plutôt que de sexe masculin, pour après ça essayer de trouver une façon d'intervenir ou de réduire ce type de problème-là. Mais fondamentalement c'est le genre d'alternatives qui sont envisagées dans ce type de programme-là, et avec lesquelles on apprend, on essaie d'apprendre en tous les cas, à partir d'histoires de cas souvent tirés de

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sociétés qui sont assez loin des nôtres, ce qui permet de voir d'une manière plus commode les différents facteurs qui interviennent, et après ça appliquer ça concrètement dans notre milieu habituel de travail; dans notre société, par exemple.

Me JOYAL:

.5/0060 Q- Vous avez parlé aussi d'un cours d'économie de la santé. Pourriez-vous m'indiquer ce...

LA COUR:

On pourrait peut-être en parler à deux heures et quinze (14:15).

SUSPENSION DE LA SÉANCE.

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L'an mil neuf cent quatre-vingt-dix (1990),

ce vingtième (20e) jour de mars:

Me MITCHELL:

Pour RJR-Macdonald, Doug Mitchell. Maureen Currie est partie.

Me POTTER:

Et pour Imperial, Simon Potter.

Me JOYAL:

Pour le Procureur général, Maîtres Simon Evraire et Claude Joyal.

Me EVRAIRE:

Simon Evraire? Vous me flattez!

Me POTTER:

Est-ce que vous flattez Simon ou Evraire?

Me JOYAL:

Les deux (2). Maître Paul Evraire.

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L'an mil neuf cent quatre-vingt-dix (1990),
ce vingtième (20e) jour de mars,
A COMPARU:

FERNAND TURCOTTE,

LEQUEL, étant sous le même serment,
dépose et dit ce qui suit:

INTERROGÉ PAR Me CLAUDE JOYAL,
pour l'intimé:

Q- Docteur Turcotte, lorsqu'on s'est quittés vous deviez nous entretenir de ce que c'était, des cours d'économie de la santé. Est-ce que vous pourriez nous expliquer qu'est-ce que sont des cours d'économie de la santé?

R- Bien, Votre Seigneurie, vous savez que dans les sociétés, on a le choix entre deux (2) méthodes pour balancer les productions avec les désirs des citoyens. On a soit les mécanismes de marché, soit la planification. Les mécanismes de marché, c'est le mécanisme qu'on utilise dans les sociétés dites modernes, bourgeoises, démocratiques, capitalistes, enfin dépendant de la couleur politique qu'on utilise pour qualifier celles-ci; et des économies planifiées, les prototypes, c'est des économies centralisées,

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autoritaires, ou socialistes, ou... dont la soviétique est le prototype le plus achevé, si vous voulez.

Le problème particulier en économie de la santé, c'est que les services de santé violent systématiquement les sept (7) principes qui déterminent le fonctionnement normal d'un marché, et ça appelle donc toute une série, si vous voulez, de contraintes particulières qui expliquent pourquoi les mécanismes de marché sont en général incapables d'allouer correctement les ressources entre les différents secteurs de besoins en matière de services de santé dans une société; et ça explique, par extension, pourquoi même dans les sociétés très libérales, ou très bourgeoises, on finit par accepter -- souvent contre son propre gré -- de devoir planifier jusqu'à un certain point les services de santé. Parce qu'on est incapables de se fier aux mécanismes de marché pour faire ça convenablement.

Et c'est essentiellement ça qu'on étudie dans un bon cours d'économie de la santé. On apprend à comprendre les caractéristiques particulières qui affectent la demande pour les services; les caractéristiques de l'offre; les types de mécanismes de contrôle qu'on peut mettre en place pour la régulation de la production, dans ce type d'industrie-là; et aussi, jusqu'à un certain point, les limitations très très

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grandes qui sont involontairement, mais appliquées à la souveraineté du consommateur, puisque les mécanismes de marché supposent qu'il y a deux (2) principes de base qui sont respectés.

Il y a d'abord que le consommateur est souverain, et que d'autre part... et que la continuité de cette souveraineté-là, sa seule rationnelle quand il vient sur le marché, c'est de maximiser sa satisfaction. Alors que du côté du producteur, le producteur est exclusivement motivé par la recherche du profit. Dès qu'un producteur poursuit d'autres types de motivations, il introduit, si vous voulez, ce qu'on appelle des "diséconomies" ou des sources de gaspillage dans la production des services.

Et, en particulier dans le domaine des services de santé, c'est caractéristique. Les consommateurs sont en général incapables d'assumer leur souveraineté. Très souvent, ils savent pas de quoi ils ont besoin; ou très souvent ils sont des consommateurs obligés. Quelqu'un qui a une fracture du crâne, ou qui a une rupture d'utérus, a pas le choix de consommer ou pas. Que ça coûte cher ou pas, il faut qu'il consomme. Et donc, en conséquence, il peut pas se retirer du marché s'il trouve que le prix lui convient pas, ou que le type de service qu'on lui offre correspond pas exactement à ce qu'il attend.

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LA COUR:

Q- Qui est déduit à la source.

R- Oui, surtout dans ce domaine-là. Comme producteur, c'est un peu la même contrainte que nous avons. En général, les professionnels de la santé trouvent extrêmement répugnante l'idée de maximiser le profit en pratiquant leur profession -- mais de fait c'est vrai de toutes les professions libérales, dites libérales. Et c'est tellement vrai que, de fait, on en est venu à considérer comme étant vaguement immorale l'idée même de poursuivre son profit dans les services de santé. C'est pour ça que la plupart des hôpitaux, par exemple, sont des hôpitaux organisés sous le troisième paragraphe de la Loi des compagnies, c'est-à-dire à titre de corporations à but non lucratif; qu'aux États-Unis, depuis le début des années quatre-vingt ('80), on voit réapparaître des chaînes de corporations hospitalières à but lucratif, et que c'est assez mal accepté par la population en général, parce qu'on trouve que c'est vaguement immoral que d'essayer de faire du profit à même la misère des gens, à même la maladie qui les afflige.

Bref, c'est autant d'anomalies, si vous voulez, qui déterminent un champ particulier, ou surspécialisé, de la science économique, et qu'on appelle l'économie des

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services de santé, et qui fait partie du curriculum normal des études... des études avancées en santé publique.

Me JOYAL:

Q- Alors, c'est ce qui vous a amené, en fin de compte, à obtenir un M.P.H. en... une maîtrise en santé publique?

R- C'est vrai.

Q- Toujours en regardant votre c.v. à la page un (1), au niveau des qualifications professionnelles. Au bas, il est mentionné votre admission au Conseil médical du Canada en 1966, et, par la suite, il y a un décalage de quinze (15) ans, avant la reconnaissance, le C.S.P.Q.; est-ce que vous pourriez nous expliquer ce qu'est le C.S.P.Q. et pourquoi il y a un décalage de quinze (15) ans entre votre admission à la pratique médicale et l'octroi de cette reconnaissance?

R- Le C.S.P.Q., Votre Seigneurie, c'est l'abréviation pour le titre de certificat... certificat de spécialiste de la province de Québec. Pourquoi ç'a pris quinze (15) ans pour l'obtenir, c'est que, en partie, parce que ça me prend du temps à apprendre...

LA COUR:

C'est déjà un bon signe, ça, quand même. Ce que vous apprenez, vous l'apprenez, vous le retenez par contre.

R- Mais c'est aussi dû au fait que les programmes de

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spécialité, c'est-à-dire l'octroi de certificat de spécialiste de la province de Québec, ont été modifiés entre la période soixante-quatorze ('74), quatre-vingt-un ('81), alors qu'à partir de soixante-quatorze ('74) il y avait pas d'examen de spécialité. Et le premier examen a été organisé en quatre-vingt-un ('81), une fois que une première cohorte, si vous voulez, de spécialistes éligibles, a été formée. Or, ces spécialistes-là ont été formés dans les programmes que nous, les universités, avons mis en place à partir de soixante-quatorze ('74).

Alors jusqu'à un certain point, on a passé l'examen en même temps que nos premiers étudiants. En fait, ça été mon cas, puisque c'est un certificat qui est obtenu ça à l'examen. Et ça explique le décalage de quinze (15) ans. Enfin, en partie.

Me JOYAL:

Q- Et la même année, vous avez obtenu un certificat de spécialiste en médecine communautaire du Collège royal des médecins et chirurgiens du Canada?

R- Oui. Alors, le Collège, le certificat de spécialiste du Collège royal, lui, est l'analogue du certificat de spécialiste obtenu du Collège provincial, le Québec étant la seule province qui exige d'examiner elle-même les spécialistes qu'elle certifie. Toutes les autres

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provinces ayant délégué cette responsabilité-là au Collège royal des médecins et chirgurgiens du Canada. Moi j'ai passé les examens aux deux (2) endroits en bonne partie, parce que c'était une façon de se solidariser du travail de rajeunissement et de révision des programmes de santé publique, ou médecine communautaire, ou de santé communautaire, dépendant des juridictions, qui s'est déroulé un peu partout au Canada au même moment; et c'est une façon aussi de s'assurer qu'on va garder un minimum d'influence dans le développement de ces programmes-là éventuellement. Et, ayant donc le C.S.P.Q., ça me donnait le droit de postuler pour le F.R.C.P., puisque le F.R.C.P., de fait, est le titre qui appartient à ce qui constitue le Collège Royal des médecins et chirurgiens du Canada, ce qu'on appelle: "Les associés", et qui de fait... l'associé doit obligatoirement détenir un certificat de spécialiste du Collège royal; mais il faut être associé pour avoir accès aux fonctions électives du Collège -- et notamment, dans mon domaine, et ce qui à l'époque, prête... ou enfin, continue à prêter en conséquence, c'est que c'est les comités de spécialité, qui contrôlent au fond l'évaluation des candidats qui sortent des programmes de spécialité. Et ceux qui contrôlent l'évaluation, finissent par contrôler les

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programmes.

Et c'est à ce titre-là, donc, que j'ai pu éventuellement devenir membre du comité de la spécialité en médecine communautaire, et éventuellement le présider, pendant une période qui s'est terminée le premier (1er) janvier quatre-vingt-neuf ('89), une période de cinq (5) ans.

LA COUR:

Comme je disais tout à l'heure: quinze (15) ans, mais ça valait la peine!

Me JOYAL:

Q- F.A.C.P.M., est-ce que vous pourriez nous expliquer qu'est-ce que...

R- Alors F.A.C.P.M., c'est, le sigle signifie "Fellow of the American College of Preventive Medecine", et donc c'est l'analogue de ce que, de ce que, du F.R.C.P.(C), sauf que ça s'applique, bien sûr, pour le territoire américain. A la différence du F.R.C.P.(C), cependant, le F.A.C.P.M. a été donné sur examen des mes titres et non pas sur un examen écrit et oral, comme au Collège royal. Et j'en fais partie à bonne... essentiellement, parce que comme enseignant de santé publique, toute l'information qui concerne le développement des programmes américains, de fait, est, au fond, filtré, et filtré, formaté, redistribué par

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l'"American College of Preventive Medecine", alors c'est une façon commode pour nous de nous tenir à jour, sur ce qui se passe aux Etats-Unis, connaître les programmes qui existent là-bas; et surtout, pour identifier les bons programmes auxquels on est intéressé à envoyer nos propres étudiants, dans le cadre de leur formation pour une période de... une période de un (1) ou deux (2) ans.

Q- Est-ce que je peux vous inviter à tourner à la page deux (2) de votre c.v., au niveau des expériences professionnelles. Vous nous aviez mentionné que vous avez servi dans les Forces armées canadiennes de soixante-sept ('67) à soixante-dix ('70); par la suite, quelles ont été vos activités jusqu'à ce jour?

R- Et bien, en quittant les Forces armées, en soixante-dix ('70), je suis retourné à l'Université pour faire ma maîtrise de santé publique; et je suis après ça... j'ai été recruté par l'Université Laval comme professeur adjoint, dans son nouveau département de médecine sociale préventive, qui de fait, démarrait à cette époque-là. L'acceptation d'un poste de professeur à l'Université Laval, en faculté de médecine, stipule que nous acceptons aussi des charges hospitalières, pour une partie de notre temps, qui est défini par contrat -- et, dans mon cas, c'était à l'époque vingt-cinq pour cent (25%) de mon temps; ce que j'ai donc commencé à faire

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dans le département de médecine interne, d'abord, du Centre hospitalier de l'Université Laval, puisque le département de santé communautaire n'a été organisé qu'à partir de soixante-quatorze ('74). Et je continue, jusqu'à ce jour, à y pratiquer ma profession, à temps partiel, pour à peu près vingt pour cent (20%) de mon temps.

Q- Si on reprends votre c.v., à la page deux (2), et en partant du bas, là, sous "expérience professionnelle": "médecin actif - département de santé communautaire, Centre hospitalier de l'Université Laval", est-ce que vous aviez une responsabilité particulière?

R- Bien, c'est-à-dire que... à l'origine j'étais un médecin actif, ce qui est la façon correcte de décrire un médecin qui a des privilèges complets d'admission dans un hôpital, par opposition à un médecin consultant, ou un médecin honoraire, par exemple. Et dans le contexte... Donc j'ai toujours été un médecin actif, j'ai toujours eu pleins privilèges de pratique professionnelle à l'intérieur de ce centre hospitalier-là.

Et éventuellement, en soixante-quinze ('75), je suis devenu le directeur, ou le chef du département de santé publique à l'intérieur de cet hôpital-là, mais c'était toujours, si vous voulez, dans la continuité de

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la portion de mon temps, du quart de mon temps qui doit être consacré à la pratique hospitalière. Et dans le cadre de cette pratique hospitalière-là, il est important que vous compreniez que ce ne sont pas les patients individuels que je traite -- c'est pas pour ça que j'ai été recruté, (même si, pendant un bon bout de temps, j'ai dû accepter de faire ça aussi), enfin... où j'ai dû accepter ça; j'ai pratiqué longtemps la médecine clinique, donc c'était normal. Mais mes responsabilités, pour l'essentiel, consistent à assumer les responsabilités de santé publique pour les populations d'Inuits qui habitent les côtes de la baie d'Ungava et de la baie d'Hudson, en vertu d'un contrat de service que mon hôpital a contracté avec les établissements hospitaliers du Grand Nord pour leur fournir ce type de services spécialisés.

17/0060 Alors dans ce contexte-là c'est moi qui suis responsable de conseiller leur système de santé en matière des grands programmes de santé publique, que ce soit surveillance des... surveillance médicale... enfin, surveillance de l'hygiène publique et de l'environnement, protection maternelle et infantile, contrôle des maladies infectieuses, prévention des épidémies... programme de santé scolaire, programme de santé au travail. Bref tout ce qui relève des champs de

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santé publique pour les dix mille (10,000) Inuits qui habitent les seize (16) communautés de ce deux (2) côtes-là, c'est mon hôpital qui est responsable, et à l'hôpital c'est moi qui suis la personne physique chargée d'assumer cette responsabilité-là.

Q- La mention "Chef - Département de santé publique, Centre hospitalier de l'Université Laval", je présume que ça comportait des responsabilités particulières; pourriez-vous nous les expliquer?

R- Alors pendant la période où j'ai été responsable du département de santé publique, à ce moment-là j'étais responsable de diriger, dans mon hôpital, un département de santé publique qui faisait, pour le territoire du C.H.U.L. -- de santé communautaire -- ce que je fais maintenant dans le Nord. C'est-à-dire qu'au lieu de m'occuper de dix mille (10,000) personnes dans treize (13) villages, je m'occupais de trois cent mille (300,000) personnes à peu près, réparties dans quatre (4) comtés; c'est-à-dire le comté de Chauveau... Alors voyez-vous, j'ai été démo... c'est une sorte de démotion.

LA COUR:

Q- Non non, c'est pas ça. Je pensais que vous alliez dire trois cent mille (300,000) personnes dans un village.

R- Non.

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Q- Mais on n'oserait jamais appeler la ville de Québec un village.

R- Oui. C'est... de fait, les responsabilités de santé publique qu'assume le C.H.U.L. concernent les populations qui habitent les comtés de Chauveau, Louis-Hébert, Portneuf et Lotbinière. Et dans ce territoire, donc, qui est au fond essentiellement la partie ouest de la région métropolitaine de Québec, -- ou devrais-je dire plutôt de la région urbaine de Québec, -- était, si vous voulez, couvert par le même type de services que dans le Nord: protection des maladies... contre les maladies infectieuses, protection maternelle et infantile, programme de santé scolaire, programme de santé au travail, surveillance de l'environnement; bref le même type de services, sauf sur une population urbaine rassemblée sur un territoire plus petit cependant.

Me JOYAL:

Q- Et quant au poste de directeur de département de médecine sociale et préventive à l'Université Laval de soixante-dix-neuf ('79) à quatre-vingt-cinq ('85)?

R- En mil neuf cent soixante-dix-neuf (1979) mon directeur de département à l'université est devenu doyen de la faculté, et c'est moi qui a été choisi pour le remplacer. Et à ce moment-là, donc, j'ai temporairement

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dû quitter pour l'essentiel mes charges hospitalières, puisque je devenais responsable d'une équipe dans laquelle il y avait à l'époque une quarantaine de personnes, dont les deux tiers ou les trois quarts étaient à toutes fins pratiques supportées par des subventions, donc c'est-à-dire des budgets constamment à non seulement renouveler, mais à réobtenir dans un cadre de compétition, et j'ai été donc un universitaire pur, à toutes fins pratiques, de soixante-dix-neuf ('79) à quatre-vingt-cinq ('85).

Q- Et quand on parle de la période quatre-vingt-cinq - quatre-vingt-six ('85-'86)?

R- Alors quatre-vingt-cinq - quatre-vingt-six ('85-'86) j'ai été professeur visiteur à l'Université de Londres, au "London School of Hygiene and Tropical Medicine". Et j'ai été dans cette université-là comme boursier de l'Association des universités du Commonwealth, pour deux (2) motifs principaux. Londres était la seule université anglophone hors d'Amérique qui offrait un programme d'études avancées en santé au travail; et comme notre propre programme avait été modelé sur l'expérience des universités américaines, j'étais assez soucieux, surtout que notre programme avait été lancé quatre (4) ans auparavant, de voir comment il se situait par rapport au programme anglais. C'était le premier

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motif.

Le deuxième motif, c'est que, parmi mes intérêts de recherche, je m'intéresse aux effets de santé liés à l'exposition des populations en général aux métaux lourds et...

LA COUR:

Q- Aux... pardon?

R- J'essaie d'étudier, d'élucider les effets de santé, ou les problèmes de santé...

Q- Aux métaux lourds?

R- ... qui sont -- oui, c'est ça -- causés par certains métaux lourds, dont le cadmium. Et un des meilleurs chercheurs sur le cadmium, à l'époque... en tout cas un des meilleurs chercheurs, le docteur George Kazantzis, était professeur au département de santé au travail du "London School of Hygiene and Tropical Medicine", et c'est la raison pour laquelle je voulais aller travailler avec lui. Et comme professeur visiteur à cette université-là, j'avais une petite charge de cours qui était essentiellement de donner en anglais un cours que je donne à Laval aux étudiants gradués, en anglais cette fois-ci cependant, et de diriger la thèse de deux (2) étudiants de maîtrise et de travailler sur mes propres... mes propres travaux, ayant accès à la bibliothèque de l'université et au centre de traitement

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de l'information.

Me JOYAL:

Q- Et depuis cette période-là, vos fonctions sont...?

R- Au retour de mon séjour de Londres, j'ai retrouvé mon poste de professeur. J'étais professeur agrégé à l'époque, à l'université, et je suis redevenu un Indien dans le département que j'avais dirigé pendant... pendant six (6) ans; et j'ai repris... j'ai repris l'essentiel de mon travail, c'est-à-dire pour quatre-vingt pour cent (80%) de mon temps du travail à l'université, d'enseignement et de recherche, et pour vingt pour cent (20%) de mon temps du travail à l'hôpital en santé communautaire.

Q- À la page un (1) de votre rapport, vous mentionnez en plus que vous avez été professeur invité par les universités de Saskatchewan, McMasterville, Toronto, McGill, de Montréal et de Lille, en France. C'est durant quelle période?

R- Bien, c'est durant la période qui couvre le début de ma carrière d'enseignant, soit depuis soixante et onze ('71), et ça se continue. Je veux dire, à peu près à chaque année je reçois une invitation pour enseigner dans une autre université. Enfin, je reçois plusieurs invitations, mais j'essaie d'en accepter à peu près une par année. Cette année, c'est Rouen. Ça dépend des...

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ça dépend des moments.

Q- Toujours à la page deux (2) de votre rapport, on va passer à la partie "Associations professionnelles et sociétés savantes". J'ai simplement qu'une question, parce qu'au bas de la page, vous indiquez "International Physicians for the Prevention of Nuclear War". Pourriez-vous nous expliquer qu'est-ce que cette organisation?

R- Alors c'est une... c'est essentiellement une société d'éducation médicale qui a pour objectif de former les médecins aux conséquences médicales qu'aurait une attaque nucléaire sur leur pays. Une association qui a été fondée au début des années soixante ('60) et qui a fini par recruter maintenant au-delà de deux cent vingt-cinq mille (225,000) médecins, je pense, à travers le monde. Et c'est une organisation qui a fait un travail suffisamment... suffisamment efficace en tous les cas pour être reconnue par l'académie Nobel, puisque vous savez que c'est l'association qui, en quatre-vingt-cinq ('85), a gagné le Prix Nobel de la paix. C'est vraisemblablement le plus proche que j'approcherai jamais pour moi du Prix Nobel, de toute façon.

Q- Si on passe à la partie de vos publications, soixante-dix-huit ('78) à quatre-vingt-dix ('90), est-ce

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que vous pourriez nous expliquer de quoi traitait la première publication qui est mentionnée au haut de la page trois (3): "Benedetti et Turcotte"?

R- Oui, alors Votre Seigneurie, c'est une étude, dans laquelle on a essayé de mesurer si les Inuits étaient contaminés par le cadmium qu'on trouve en très grande quantité dans les abats de caribou, qui constitue pour cinq (5), même six (6) des seize (16) villages, un aliment, un aliment de choix. Et, de fait, on a trouvé des quantités très élevées de cadmium urinaire -- des quantités encore plus élevées de cadmium sanguin -- mais on a trouvé aucune association de ces concentrations-là avec la consommation... la consommation d'abats de caribou. De fait, le seul, semble-t-il, la seule source de contamination externe qui explique ce phénomène-là chez-eux, c'est leur consommation de cigarettes, puisque le cadmiun est un contaminant qui est là depuis très longtemps -- depuis au moins, depuis le XVe ou XVIe siècle -- qui se retrouve dans la nature, à l'origine, par un mécanisme de lixiviation naturelle, mais qui se recycle dans la chaîne alimentaire, parce que les feuillus, en général, le concentrent. Et ce qui explique que le caribou a été si profondément contaminé avec ceci; le caribou, pour l'essentiel, leurs diètes, c'est des lichens -- des lichens c'est des feuillus qui

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concentrent le cadmium -- et le cadmium est fixé sélectivement dans deux (2) organes: les reins et le foie; et bien sûr, la consommation de ces aliments-là peut donner des doses massives... des doses massives de ce métal-là.

Dans les faits, on retrouve le cadmium à peu près partout dans la nature, on le retrouve dans les diètes, on le retrouve dans les salades, on le retrouve dans les aliments... des aliments qui sont mis en conserve; mais c'est une des... c'est un des bénéfices secondaires inattendus de la consommation de tabac... c'est qu'il se retrouve dans le tabac, il est absorbé de façon terriblement efficace, sous forme gazeuse, par le poumon. De telle sorte que le fumeur de vingt (20) cigarettes par jour, par exemple, double à peu près sa... son absorption de cadmium par vingt-quatre (24) heures.

Le problème avec le cadmium, c'est que c'est un métal lourd qui a pas d'utilité biologique connue, présentement, et qui, une fois qui est absorbé, a une demi-vie dans l'organisme humain, qui se compte en années, entre dix-sept (17) et trente (30) ans, dépendant des auteurs; et qui est donc terriblement difficile d'éliminer correctement. Et ça devient important de comprendre le mieux possible, d'une part le

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métabolisme de ce contaminant-là, et d'autre part sa répartition dans la population générale; alors on n'a pas beaucoup de données là-dessus.

Et le travail que nous faisons chez les Inuits... enfin, s'inscrit dans les efforts qui sont entrepris un peu partout pour essayer d'élucider ce problème-là.

Q- A la page quatre (4) de votre c.v., il y a une référence, et j'aimerais savoir de quoi elle traite. Les textes écrits en collaboration, le troisième: "Rapport du Comité d'études sur les normes médicales des agents de la paix." Pouvez-vous nous expliquer qu'est-ce que c'est?

R- C'est le rapport de... en fait, c'est des travaux d'un comité d'études qui avait été mandaté par la Commission de police... la Commission de la fonction publique d'abord, du Gouvernement du Québec en soixante-dix-neuf ('79), parce que les normes qui étaient utilisées pour recruter les policiers, les normes médicales qui étaient... qui étaient des normes qui étaient arbitraires, qui étaient injustes, et qui, au fond, finissaient par discriminer contre les petites personnes, contre les trop grandes, contre les trop grosses aussi, entre autres, et...

LA COUR:

Ils se reprennent après.

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R- Pardon?

Q- Ils se reprennent après.

R- Alors, on a, dans un premier temps, si vous voulez, on nous a demandé d'essayer de refaire le point sur la validité prédictive de ces normes-là, et on a réussi à en faire éliminer un certain nombre, mais pas toutes; de telle sorte que, l'an dernier, la Commission de police a réappointé un deuxième groupe de travail, dont je fais encore partie, pour achever le ménage qui a été commencé sur cette période-là. Mais, je pense que c'est à la suite de ces travaux-là que la Commission de police a demandé à des collègues de l'Université Laval d'établir des normes ergonomiques qui établissent exactement de manière empirique c'est quoi la demande de ces tâches de travail-là; et c'est à la suite de l'adoption de cette étude-là qu'un test d'aptitude physique validé a été adopté, fait partie maintenant du processus de sélection, et qui explique qu'on rencontre dedans des femmes policiers, des petits policiers, etc. Leurs aptitudes physiques sont mesurées de façon beaucoup plus précise que par le gabarit de l'homme ou de la femme bionique, quatorze (14) pouces entre les deux (2) yeux, puis enfin... vous connaissez...

Me JOYAL:

Q- Vous voulez dire que c'est à vous que je dois si je peux

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rentrer dans la police aujourd'hui?

R- C'est-à-dire à moi: avec les collègues... A moi, et aussi grâce aux collègues qui ont travaillé avec moi.

LA COUR:

Et il y a des tests à passer, maître Joyal.

Me JOYAL:

Connaissance du droit.

Q- "Direction de thèses", il y a la référence à la page quatre (4), mil neuf cent quatre-vingt-neuf (1989), Moussa, qui est une étude qui porte, je pense, sur le Mali. Pourriez-vous expliquer comment il se fait que vous êtes responsable d'un étudiant qui fait une thèse sur le sujet qui est mentionné?

LA COUR:

Sida au Mali.

R- Oui. Oui, Votre Seigneurie, ç'a l'air un petit peu... un petit peu bizarre, mais mon département a un gros centre de coopération en santé et développement, et en vertu duquel nous avons un protocole de coopération technique avec l'école... l'Institut national de santé publique du Mali, à Bamako. Et en vertu de ce protocole-là, nous assurons la formation avancée d'un certain nombre de leurs professeurs, et Moussa Maiga est un de ces professeurs-là qui est en train de faire son doctorat chez-nous -- c'est-à-dire sa maîtrise à ce

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stade-ci, mais éventuellement ses trouvailles sont suffisamment importantes pour éventuellement faire l'objet d'un doctorat. Il est boursier de l'Organisation mondiale de la santé, et l'entente que nous avons avec l'Organisation mondiale de la santé, c'est que pour la réalisation de la recherche qui est requise pour leur diplomation, les travaux sont exécutés le plus près possible du terrain sur lequel... auquel ils vont retourner une fois que leur formation sera terminée.

Et comme Maiga est un professeur de l'Institut national à Bamako, c'est dans cette région-là qu'il fait sa recherche actuellement. Et donc, concrètement, il a passé dix-huit (18) mois au Québec, il est retourné chez-lui depuis un (1) an, et il revient le mois prochain, pour achever la mise en forme de sa thèse, et sa défense, et puis retourner chez-lui autour de la fin août, de la présente année.

LA COUR:

Il est venu passer le beau temps ici...

R- C'est ça. Mais remarquez, qu'il s'est envoyé un hiver québécois quand même.

Q- Oui... bon, bien tant mieux.

Me JOYAL:

Q- A la page cinq (5) de votre c.v., à la rubrique "1988",

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le troisième étudiant: Marie Olivier, semble pas être un médecin. Pourriez-vous nous expliquer comment il se fait que cette personne-là fait une recherche en santé publique?

R- Oui. Dans mon département, parmi les étudiants des programmes avancés, il y a toute sorte de "zigotos", je devrais dire. Il y a même des avocats, vous savez. Il y a... de fait, Marie Olivier est un dentiste qui a fait sa maîtrise en épidémiologie et qui a mesuré. qui de fait, a réalisé une recherche avisée évaluative, comparant deux (2) types d'intervention de santé publique sur les problèmes, les problèmes de carie dentaire. Mais Nathalie Dubé, qui vient juste avant elle, est une physio-thérapeute; Suzanne Bruneau, en dessous, est un sociolgue; Owolabi est un médecin; Létourneau est médecin; Laurier Tremblay, c'est un physio-thérapeute, lui aussi; Lucie Chenard, c'est une sociologue; il y a toutes sortes... il y a toutes sortes de gens qui viennent faire chez-nous une maîtrise ou un doctorat en épidémiologie, il suffit qu'ils aient une formation de premier cycle de bonne qualité, qui les rendent donc admissibles à l'école des gradués de l'Université Laval; que deuxièmement, ils aient l'expérience pertinente dans le domaine de la santé, puisque ça suppose une maîtrise du jargon, puis des

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types de contraintes. Mais une fois que ça c'est fait, puis qu'ils réussissent les cours, et qu'ils réussissent à faire un protocole de recherche pour lequel ils obtiennent une subvention...

LA COUR:

Dans le cas de madame Olivier, ce qu'on parle de l'"Efficacité d'application topique de fluorures", ça, ça va; "dispensée dans le secteur public sans prophylaxie préalable", qu'est-ce que ça veut dire ça?

R- Bon, c'est de fait, des enfants, à qui on a fait, si vous voulez, essentiellement un rince-bouche avec une solution fluorée à l'école, en classe, sans qu'ils soient vus ni par un dentiste, ni par un hygiéniste dentaire pour détartrage préalable. Ce qui est un peu la routine qui a été suivie jusqu'à maintenant. Et ce qui rendait difficile de couvrir de grandes populations en dehors des centres urbains -- puisque les hygiénistes dentaires c'est rare, si vous voulez, c'est rare en dehors des grands centres urbains. Alors, ici, l'idée d'avoir un ensemble d'interventions qui pourrait être controlé par les écoles elles-mêmes, sans aucune espèce d'intervention spécialisée autre que pour la formation des professeurs, était alléchante. Et ça permettait surtout -- ou ça permet surtout -- d'intervenir dans les régions où les familles sont pas branchées dans les

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aqueducs fluorés, ou carrément pas branchées sur des aqueducs, ce qui est le cas des populations rurales.

Me JOYAL:

Q- Puis qu'elle a été la conclusion de la thèse, par curiosité?

R- Cette thèse-là montre qu'on est capable de produire d'aussi bons résultats avec cette méthode-là qu'avec la méthode qui met en contribution les dentistes et les hygiénistes dentaires. Votre Honneur... Votre Seigneurie, c'est pas si grave que ça, ça permet de dire -- on peut répondre à ça de l'autre côté, ça veut dire que si on est capable de le faire aussi bien, avec moins de moyen, c'est qu'on est capable... probablement capable de couvrir plus grand avec les ressources qu'on a, donc c'est très encourageant comme perspective.

R- Ça reste de l'intervention qui a été conçue par des dentistes et des hygiénistes dentaires; et puis, bien montrer qu'elle est valide, c'est déjà... c'est déjà impressionnant.

LA COUR:

Produisez-vous son curriculum vitae?

Me JOYAL:

Oui, Votre Seigneurie. Ça serait AG...?

LE GREFFIER:

AG-193.

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CONTRE-INTERROGÉ PAR Me SIMON V. POTTER,

pour la requérante, Imperial Tobacco Limited:

Q- Docteur, avec votre c.v. et avec les explications que vous venez de donner, je ne contesterai certainement pas votre expertise dans les domaines que vous venez de mentionner, mais j'aimerais bien savoir quelle expérience vous avez dans d'autres domaines -- et je ne vois dans votre c.v. rien qui traite de la publicité. Est-ce que nous pouvons prendre pour acquis que vous n'avez jamais fait de travail dans le domaine de la publicité?

R- Vous pouvez prendre ça pour acquis, j'ai pas d'expérience professionnelle comme concepteur de publicité, mais j'ai quarante quelques années d'expérience comme consommateur de publicité.

9/0053 Q- Comme d'ailleurs plusieurs dans la salle ici.

R- Oui.

Q- Et comme plusieurs dans l'autobus.

R- Oui.

Q- Oui. Et aussi, je ne vois rien dans votre c.v... vous n'avez jamais écrit d'articles ou fait de recherches spécifiques dans le domaine du tabac?

R- Non.

Q- Non plus.

R- Non plus.

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Q- Et si je comprends bien, vous n'avez non plus fait de recherches spécifiques ou écrit d'articles dans le domaine de la dépendance?

R- Non plus.

Q- Et aussi, si je comprends bien, dans le domaine des sondages? Vous n'avez pas fait de sondages, ni conçu de sondages, et vous n'avez pas d'expertise pour les comprendre ou les interpréter ou juger de la confiance qu'il faudrait y attacher?

R- Non, j'ai pas d'expérience de sondages, mais j'ai besoin, Votre Seigneurie, de qualifier cette réponse-là. J'ai été pendant... pendant sept (7), huit (8) ans le titulaire du cours "Techniques d'enquête en épidémiologie", dans mon université, et c'est un cours qui précisément enseigne les façons correctes de concevoir des études par sondage. Alors dans ce contexte-là, plaider l'ignorance de ma part serait induire la Cour en erreur, mais je n'ai pas pour ma part jamais conduit de sondages d'opinion.

Q- Voilà. C'est ce que je visais, docteur. Merci.

LA COUR:

Maître Mitchell?

Me MITCHELL:

Aucune question, Votre Seigneurie.

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LA COUR:

Alors vous êtes qualifié comme expert dans votre champ de compétence. J'ai lu évidemment son rapport.

Me JOYAL:

Moi aussi, mais j'ai pas tout compris, Votre Seigneurie, fait que je vais être obligé de lui poser des questions.

R- Je pense, Votre Seigneurie, que ce serait important que je vous indique que j'ai au moins... j'ai repéré au moins quatre (4) erreurs où il y a une petite imprécision dans l'identification de la référence. À la page huit (8), par exemple, je m'en excuse, à la toute fin du texte, il y a les références 8 et 9. C'est pas là qu'elles devraient se trouver, mais juste à la fin de la phrase précédente. Il y a eu un réaménagement, là, du...

LA COUR:

Q- Bon, aux maladies cardiaques, là? Qui se termine par "maladies cardiaques"?

R- C'est ça. C'est ça. Alors 8 et 9 devraient aller là, plutôt qu'après "cigarette".

Q- Oui.

R- À la page...

Q- Un petit... un instant.

R- Pardon.

Q- "Cardiaques". Oui.

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R- À la page neuf (9), la page suivante donc, à peu près au milieu du ... au milieu de la page, il y a une ligne qui commence par "(800,000 personnes)", on y met référence 11. C'est au milieu de la page à peu près.

Q- Oui.

R- Dixième ligne.

Q- Um-hm.

R- On y met référence 11; ça devrait être la référence 13. Je m'excuse, je me suis aperçu de ça hier soir.

Q- Référence 13, oui.

R- Alors à la page... à la page onze (11) maintenant; la page onze (11), le dernier paragraphe, à peu près au début du troisième tiers du dernier paragraphe, il y a une référence qui est identifiée 15.

Q- Um-hm.

R- Alors, de fait, ce chiffre-là devrait être déplacé un petit peu plus haut dans la phrase, trois (3) lignes plus haut, et mis après "l'année qui a précédé l'enquête". Ce serait une façon plus correcte en tous les cas de présenter ceci.

Q- "Année qui a précédé l'enquête". Alors ça va après "enquête"?

R- Ça va après "enquête", c'est ça.

Q- "Enquête".

R- À la page douze (12), c'est la page suivante, le dernier

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paragraphe, la troisième ligne du haut, il y a une phrase qui se termine par le mot "tabagisme", avec référence 16; qu'il faudrait plutôt remplacer par 15. Je suis confus, mais c'est diabolique ces choses-là.

LA COUR:

Pas d'objection?

R- Maintenant j'ai...

Me POTTER:

Euh, pas d'objection... au mot "diabolique", non, je comprends.

R- Ce que je veux dire c'est diabolique, c'est les erreurs de transcription.

Me POTTER:

Elles sont partout tout le temps.

R- Maintenant j'en avais une dernière, Votre Seigneurie. C'est à la page treize (13), et c'est à la fin, à la toute fin du premier paragraphe. Le mot "la même période" est suivi de la référence 22, et c'est une erreur, il s'agit toujours de la référence 15. Je suis... et c'est les dernières corrections que... que je m'excuse de vous apporter à ce moment-ci et que je vous prie d'accepter.

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INTERROGÉ PAR Me CLAUDE JOYAL,

pour l'intimé:

Q- Docteur Turcotte, comme je vous ai dit, là, considérez-moi comme un de vos étudiants. Pourriez-vous me définir ce qu'est un spécialiste en santé publique.

R- Oui, je pense que je peux essayer de... je peux essayer de faire ça, même si j'ai entendu tellement... tellement d'utilisations particulières du mot "santé publique" que je suis à la veille d'en avoir des boutons. Il y a quatre (4) sens à "santé publique", et c'est important, je pense, de faire la distinction, Votre Seigneurie, entre ceux-là.

Au sens strict du terme, "santé publique" c'est synonyme de l'expression épidémiologique: "état de santé d'une population". État de santé comme on l'estime, comme on le mesure de façon indirecte à partir des taux de mortalité, des taux de morbidité, des taux d'infirmité, ou des années potentielles de vie perdue, bref toute une série d'indices dont on vous a... avec lesquels on vous a usé la patience au cours des dernières semaines, en tous les cas.

LA COUR:

Q- Moi aussi, j'ai des boutons.

R- Il y a un deuxième sens que... je vais appeler le premier sens élargi du terme. L'expression "santé

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publique" désigne l'ensemble des institutions qu'organisent et maintiennent les sociétés pour intervenir sur la mortalité prématurée. Et le prototype de ceci, c'est les ministères de la Santé qu'on a, les bureaux municipaux de santé dont on se dote, et souvent les directions de la Santé que même les... que les sociétés s'organisent en leur sein.

Il y a une extension de cette définition-là, que je vais appeler le sens élargi numéro 3, qui est... qui finit par faire que "santé publique" est utilisée pour désigner les champs ou les domaines dans lesquels interviennent ces institutions. Alors on dit: en santé publique. En santé publique, par exentension, c'est là où interviennent les organismes de santé publique; et à force de parler de ceci, on finit par plus savoir exactement de quoi on parle.

Et il y a le dernier sens, qui est celui à propos duquel la question est posée, Votre Seigneurie, et qu'est-ce que c'est qu'est la définition médicale, le sens médical de l'expression "santé publique". C'est essentiellement une spécialité médicale qui porte cependant plutôt les vocables de "médecine communautaire" ou "santé communautaire". Dans certains pays, ça s'appelle encore santé publique -- il y a des médecins spécialistes en santé publique. Et comme

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spécialité médicale, la définition de "santé publique", c'est essentiellement la science et l'art de prévenir la maladie, de prolonger la vie et d'améliorer la santé.

Et ça, c'est une définition qui a été proposée par Winslow, qui a été formalisée au début des années... des années vingt ('20), je pense, et qui a été reprise à son compte par l'Organisation mondiale de la santé qui est, dans ma spécialité, un petit peu ce que le vatican est pour les jésuites, c'est-à-dire l'organisme qui donne l'heure juste et qui dit un peu... qui dit un peu qu'est-ce que... comment il convient de pratiquer notre profession.

Alors je sais pas si ça répond à votre question, Votre Seigneurie, c'est une réponse longue pour un concept qui a l'air... qui a l'air simple, mais il y a santé publique -- et santé publique, et santé publique, et santé publique, si je puis dire; et celle que je connais le mieux, bien sûr, c'est la spécialité médicale que je pratique depuis une vingtaine d'années.

Me JOYAL:

Q- Pourriez-vous nous dire quels sont les outils dont dispose un spécialiste de la santé publique pour traiter un problème de santé chez une population?

R- Oui. Le médecin spécialiste de la santé publique, son premier instrument de travail c'est l'histoire naturelle

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des problèmes de santé sur lesquels il doit intervenir. Il faut avoir d'abord une bonne... une bonne description de ce qu'est l'histoire naturelle de la maladie. Une fois qu'on a ça, le deuxième instrument qu'on utilise c'est les programmes qui sont requis pour modifier les facteurs de risque modifiables qui expliquent la répartition d'une maladie dans la population.

Dit en d'autres termes; si j'étais placé face à une maladie qui est distribuée strictement aléatoirement dans une population, il y a aucune solution de santé publique qui puisse s'appliquer à cette maladie-là, puisque elle n'est rigoureusement pas connaissable avec les instruments d'analyse dont nous disposons. Et donc, dans ce contexte-là, en face d'une maladie distribuée aléatoirement, je n'aurais pas d'instruments. Je serais vraiment dans une situation d'impuissance complète. Et il y a beaucoup de problèmes de santé qui, de fait, nous confinent dans cette situation-là, puisque ils sont trop mal connus pour qu'on soit capables d'expliquer leur répartition dans la population par des facteurs de risque qui se prêtent à modification.

Et ça c'est la deuxième caractéristique. Une maladie qui ne s'expliquerait que par l'âge, par le sexe ou par l'occupation -- bien rigoureusement parlant, on peut rien faire pour ça. Parce qu'on peut pas changer

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son sexe, on peut pas changer son âge, puis on peut pas changer son occupation ou ses antécédents professionnels.

Ce qui nous intéresse c'est les facteurs de risque qui se modifient, parce que, eux, de fait, sont susceptibles, lorsqu'on réussit à les modifier dans la population, d'altérer l'évolution de l'histoire naturelle de la maladie, et donc de réduire la mortalité prématurée, ou la morbidité prématurée.

Le troisième type d'outil dont nous disposons, c'est les mécanismes de contrôle qu'on établit sur les maladies transmissibles, en utilisant des procédures qui sont essentiellement des procédures de surveillance. Soit à la surveillance médicale qu'on va imposer à des travailleurs qui s'adonnent à être exposés à des nuisances dans le cadre de leurs occupations, soit les registres de cancer dont on a parlé à plusieurs reprises devant ce Tribunal, soit le registre des maladies à déclaration obligatoire, ou soit les registres d'intoxication, par exemple, qu'on constitue dans certains groupes industriels pour s'assurer que les mécanismes d'hygiène industriel ne sont pas pris en défaut. Donc méthode de surveillance de populations.

20/0112 Quatrième famille d'instruments, c'est ce qu'on regroupe sous le vocable général de l'"éducation

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sanitaire", et qui décrit essentiellement... peut-être l'instrument qu'on utilise le plus volontiers puisque, au fond, la servitude ou l'obligation professionnelle numéro 1 du spécialiste de santé communautaire, c'est de rendre disponible l'information qui prête à conséquence pour la santé. Et notre travail, c'est donc de produire cette information-là, puis deuxièmement de la vulgariser, de manière à ce qu'elle soit assimilable par le commun des mortels.

Et d'ailleurs, dans ce domaine-là, j'aime souvent, moi, en tous les cas, utiliser avec mes étudiants un mot d'ordre que monsieur Mahler, qui était l'ancien directeur général de l'Organisation mondiale de la santé... Mahler aimait dire, et je le cite: "Vous n'avez fini votre travail que lorsque vous avez défini un problème avec suffisamment de précision pour que sa solution soit applicable en toute sécurité par des analphabètes."

Ce qui est une façon de traduire l'obligation de santé communautaire -- ou de santé publique -- de rendre appropriable par les éléments les moins... les moins peut-être sophistiqués d'une société, les éléments qui sont critiques, pour protéger et préserver la santé. Et c'est un peu ce qu'on regroupe sous la grande étiquette "éducation sanitaire".

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Le contrôle de l'environnement est la cinquième famille de méthodes que nous utilisons; et le contrôle de l'environnement prend différentes... différentes façons. Dans nos sociétés, en général c'est par voie d'identification des contaminants, de réglementation des... parfois c'est la meilleure façon. Quand un contaminant, par exemple, est un constituant essentiel, une retombée inévitable, par exemple, de la production d'énergie, bien on essaie à ce moment-là de réduire périodiquement les émissions en les contrôlant. C'est là qu'on met des normes dites de "pollution" qui peuvent être appliquées soit dans la société ouverte ou soit dans le milieu industriel, ou des choses semblables.

Et finalement le dernier instrument, et qui est celui souvent qui prend le plus de place dans l'ensemble de la pratique professionnelle, c'est ce qu'on appelle l'organisation des services de santé. Et l'organisation des services de santé, ça doit être compris au sens large et au sens étroit du terme. Dans les sociétés très développées comme la nôtre, c'est pas une grosse responsabilité de la santé publique puisque les institutions sont en place, les hôpitaux existent, les professions sont bien organisées, se reproduisent, s'entretiennent elles-mêmes, donc à ce moment-là la santé publique peut se confiner à son champ plus

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immédiat d'intérêts; mais dans des situations autres, comme les situations en développement -- on parlait du Mali tout à l'heure, mais je pourrais vous parler des Comores, du Bénin, du Cameroun, Côte d'Ivoire, autant de pays où nous intervenons -- de fait, la santé publique doit tout mettre en place, à partir de la P.M.I. jusqu'à la salle d'opération, puis aux soins intensifs et, bref, tous les éléments qui sont requis, pour couvrir les problèmes de santé de cette population-là, qui comprennent, bien sûr, un certain nombre de problèmes. Que dans nos sociétés on envoie chez le cardiologue ou chez le chirurgien.

Dans les pays en voie de développement, c'est indifférencié. Cest distinctions-là sont simplement pas supportables par le système de santé, et puis, donc, c'est un seul système qui fait la dispensation de toutes les choses, et ça appartient à ma spécialité que de mettre ça en place.

(P.M.I., pour protection maternelle et infantile. C'est une façon commode qu'on a de simplifier.)

Alors ça réfère essentiellement à l'organisation de maternités, de salles d'accouchement avec, si vous voulez, un petit dispensaire, avec une équipe de sages-femmes, et puis une équipe de soutien. Quand on... Dans les systèmes fondés sur la P.M.I., c'est

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souvent l'unité fonctionnelle élémentaire, ou l'unité de soins élémentaires, ou fondamentale, avec laquelle on bâtit le système de santé: l'unité, la clinique de P.M.I., de protection maternelle et infantile.

Q- Vous avez parlé de registre des maladies obligatoires. Pourriez-vous nous expliquer qu'est-ce que c'est, le registre des maladies obligatoires.

R- Oui. Le registre des maladies à déclaration obligatoire est un registre essentiellement qui est constitué par le législateur et qui oblige, tantôt les professionnels de la santé, tantôt les laboratoires --hospitaliers ou de santé publique -- à déclarer, à l'intérieur d'un délai qui est prédéterminé, parfois qui se compte en heures (mais la plupart du temps qui se compte en semaines), quand un cas survient.

Alors la déclaration peut prendre deux (2) formes, soit -- pour certaines maladies, c'est strictement anonyme; tout ce qu'on a, c'est l'âge et le sexe de la personne, avec le diagnostic. Parfois, c'est une déclaration qui est personnalisée; et en général c'est personnalisé quand la déclaration vise aussi à déclencher ce qu'on appelle le mécanisme de protection secondaire autour d'un cas qui survient, empêcher la dissémination. Alors ça permet de faire l'enquête épidémiologique, par exemple d'identifier les contacts,

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puis d'administrer le traitement prophylactique, ou les vaccinations quand c'est la réponse qui s'applique.

Et chaque législation, chaque société moderne a une législation, une réglementation qui concerne les maladies à déclaration obligatoire, qu'on abrévie encore là avec le sigle M.A.D.O., et ça permet, si vous voulez, d'exercer une surveillance... et surtout en situation, en contexte où on n'est pas en situation d'épidémie, mais qu'on a des petits foyers qui éclatent à gauche puis à droite; ça permet d'avoir un petit peu... des mécanismes qui nous avertissent d'avance quand un problème risque de se manifester à l'état épidémique dans une population.

Alors c'est ainsi, par exemple, qu'à chaque automne on est prévenus des types de souches d'influenza qui sont identifiées, pour pouvoir voir, de fait, s'il y a eu la dérive antigénique qui est le prérequis à une nouvelle épidémie, et puis là si on doit prendre des mécanismes... enfin des moyens particuliers. Ici, nos moyens sont toujours les mêmes: On vaccine sélectivement -- mais de façon très zélée -- les personnes âgées et les malades chroniques, puisque c'est chez eux que la mortalité survient par l'influenza, et pas dans le reste de la population. Ça rend le reste de la population malade, mais les gens survivent. Mais le prix payé en

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mortalités prématurées de personnes âgées est très élevé, alors à ce moment-là on met le paquet dans ces sous-groupes-là plutôt.

LA COUR:

Q- Les maladies, j'imagine, sexuelles, également, sont à déclaration obligatoire?

R- Les maladies... oui. Pas toutes, par exemple. Certaines.

Q- Vénériennes, je devrais dire.

R- Oui, c'est-à-dire pas toutes les M.T.S. parce qu'il y en a plusieurs qui le sont pas. Mais syphilis, gonorrhée, et chlamydia depuis quatre-vingt-sept ('87), sont à déclaration obligatoire, mais c'est une déclaration qui est anonyme, celle-là.

Q- Anonyme?

R- Oui, est anonyme. Et ça nous... jusqu'à un certain point, c'est pas vraiment important que ce soit anonyme maintenant, puisque fort heureusement c'est des maladies qui sont en baisse. O.k.? La gonorrhée est en chute libre, est en chute libre en Amérique du Nord. On sait pas pourquoi. En fait on sait pourquoi... on se doute pourquoi. Mais on ne sait pas... on ne connaît pas vraiment l'explication. Il y a des nouvelles maladies qui apparaissent. Le chlamydia semble avoir remplacé la gonorrhée.

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Q- La gonorrhée.

R- Sauf que ça prête moins à conséquence, semble-t-il. Et la syphilis, elle aussi, est en voie de disparition. Je veux dire, comparativement à ce qu'était la syphilis lors de ma naissance, par exemple; ou aux États-Unis il y avait trente-cinq pour cent (35%) des enfants noirs qui naissaient avec une syphilis congénitale. Aujourd'hui c'est rarissime. Je veux dire, je dois être un des seuls médecins canadiens qui en a déjà vu des cas de syphilis congénitale, et pourtant je suis pas si vieux que ça.

R- ... on a réussi à améliorer sensiblement la couverture de la population, même avec des mécanismes aussi imparfaits de déclaration. Mais je dois dire que, Votre Seigneurie, une des raisons pour lesquelles on a rendu ces déclarations-là anonymes, c'est que de toute façon les médecins la faisaient pas la déclaration quand elle était personnalisée -- parce qu'elle a été longtemps personnalisée. Mais les médecins étaient, et je pense avec raison, plus soucieux de préserver une confidentialité d'information de particuliers, que de respecter l'esprit du règlement dans cette affaire-là; et dans la mesure où ils étaient pas toujours raisonnablement sûrs de la sécurité du mécanisme de gestion de cette information-là, je pense que leur

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décision était justifiée. Et c'est ainsi qu'aujourd'hui cette partie de la déclaration se fait sur une base anonyme, toujours dans l'espoir d'améliorer la qualité de la déclaration.

LA COUR:

O.K. Dans le cas du sida, est-ce que c'est avec identification ou sans identification?

R- Dans le cas du sida, de fait, la déclaration, elle est... elle est anonyme, si je...

Q- Ah bon.

R- Oui. Et c'est fort heureux. C'est fort heureux parce que... enfin, on pourrait en parler pendant des heures, mais, en particulier, le sida, il faut vraiment... les gens ont déjà une abominable corvée de souffir du sida, sans ajouter l'ostracisme, qui est la réaction spontanée naturelle que les sociétés sont portées à avoir face à un fléau qui est aussi grave que celui-là. D'abord, on a probablement exagéré un petit peu l'importance de ce problème-là. C'est une maladie terrible pour ceux qui la frappent, mais elle est pas si contagieuse que ça; c'est une maladie qui reste rare.

Q- Bien, je pense que c'était la preuve épidémiologique qui a suscité peut-être cette crainte-là -- mais je vous interromps comme ça, c'est pas méchamment.

R- Vous savez, Votre Seigneurie, on pourrait discuter

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là-dessus.

Q- Mais...

R- C'est les épidémiologistes qui ont fait peur au monde avec ça.

Q- C'est justement ce que je disais. Deuxièmement, pouvez-vous m'en donner une qui soit une déclaration obligatoire avec identification?

R- Oui. La typhoïde.

Q- La typhoïde? Ah.

R- La tuberculose.

Q- Encore?

R- Ah oui encore. Et c'est terriblement important, puisque dans le cas de la tuberculose, par exemple -- et là, et moi je vous en parle en connaissance de cause, j'ai encore de la tuberculose dans ma population d'Inuits, et je reçois des déclarations... bien la déclaration d'un cas va nous arriver de trois (3), quatre (4) sources différentes: du médecin traitant, du médecin consultant à Montréal, du Laboratoire de Santé Publique, puis du laboratoire de l'Hôpital St-Luc. Mais c'est important que je sache que ce n'est pas quatre (4) cas, mais c'est la même personne. O.K., pour pas... parce que dans mon... dans ma population, la différence entre un (1) cas puis quatre (4) cas, c'est la différence entre, si vous voulez, le ciel puis l'enfer. Parce que, à quatre

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(4) cas, j'ai une épidémie terrible sur les bras. Et deuxièmement, c'est pas stigmatisant; les gens, maintenant, aujourd'hui, qui ont la T.B., ça n'a pas du tout le caractère de stigmatisation que ça avait il y a quarante (40) ans. Il y a quarante (40) ans, avoir la T.B., de fait, c'était tellement stigmatisant que il y avait la T.B. qui était la maladie des pauvres, puis il y avait la phtisie qui était la maladie du tuberculeux d'Outremont. Mais c'était la même maladie. Mais on avait senti le besoin d'utiliser deux (2)... deux (2) vocables pour désigner la même entité. Alors, je pourrais vous parler du botulisme, il y a toute sorte...

Q- Arrêtez, on va revenir à notre sujet, je m'excuse. Maître Joyal.

Me JOYAL:

Q- Docteur Turcotte, comme tout bon étudiant, je veux savoir que me réserve l'avenir: quelles sont les fonctions au rôle du spécialiste en santé publique dans notre société?

R- Bien, des fonctions qui sont définies par ce que j'ai essayé de décrire comme étant le champ de spécialité: identifier les problèmes de santé, identifier les facteurs de risque qui se prêtent à modification, et qui donc sont susceptibles de corriger la partie corrigible du problème de santé; faire connaître ces

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informations-là au... à nos concitoyens, puisque c'est leur santé qui est en cause; les aider à mettre au point les programmes qui sont requis pour se protéger contre ces problèmes-là; et puis, ben... je... une fois qu'on a fait ça, on a bien gagné notre salaire. Enfin, il me semble.

Q- Voulez-vous prendre votre rapport, docteur Turcotte. J'aimerais vous référer en premier lieu à la page deux (2) parce que... au paragraphe 1.3, sous la rubrique "Présentation du mémoire", à la deuxième ligne, vous mentionnez ce qui suit:

> "Dans ce mémoire, l'auteur tentera d'abord de présenter brièvement à la Cour les modèles utilisés en santé publique (...)"

Pourquoi est-ce qu'on utilise les modèles en santé publique? Quelle est l'utilité des modèles?

R- Ben l'utilité... l'utilité d'un modèle, c'est... c'est surtout que ça permet de reconstituer rapidement, dans une situation de simulation, qu'est-ce qui se passe vraisemblablement dans une situation très complexe, qui se prête pas, elle, à modification facilement. C'est beaucoup plus facile, par exemple, de vérifier le caractère aérodynamique d'une bagnole sur un modèle dans une soufflerie que de les essayer sur les autoroutes, puis là, être pris avec les problèmes d'échantillonage,

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etc. Alors, essentiellement, en santé publique, c'est le même type... le même type de mécanisme qu'on utilise -- enfin, une extension du même modèle, -- où à partir des connaissances obtenues, dans l'histoire, on dispose de différents modèles de maladie. Il y a des modèles infectieux par exemple, des modèles infectieux qu'on appelle par... infectieux explosif, par opposition aux modèles infectieux chroniques, comme la lèpre et la tuberculose, par exemple. O.K. D'un côté, l'influenza, disons, versus la tuberculose. Des maladies qui utilisent le même modèle, c'est-à-dire les mêmes mécanismes étiologiques; c'est des maladies à bactérie ou à... provoquées par des micros organismes, mais qui se comportent pas de même façon dans les populations.

Il y a des modèles de maladies chroniques, aussi. Des modèles de maladies chroniques, aussi, à durée d'évolution très courte, des modèles à durée d'évolution très longue; et on finit par avoir des prototypes qui nous permettent, devant une situation nouvelle, présentée dans une population... Prenons l'exemple d'une épidémie, soit-disant d'anomalie congénitale qui survient dans une région du Québec actuellement; il est possible déjà, à partir d'un certain nombre de caractéristiques épidémiologiques, de juger si ç'a du bon sens ou pas. Que ce soit une épidémie causée par

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une exposition d'origine environnementale.

Et c'est à partir de ces considérations-là, qu'on est en mesure de voir, dire: "Bon, tel type de problème s'apparente à tel type de problème connu, et donc, devrait peut-être être conçu... ou la solution, en tous les cas, à ce problème-là, pourrait peut-être être conçue de la même façon qu'on a conçu ces problèmes-là."

Et c'est à ça qu'on réfère quand on parle de modèles. Dans le cadre du mémoire ici, je m'aperçois que j'ai parlé des modèles, et puis au fond, j'en présente... et j'en présente un essentiellement qui est le modèle d'interaction "Hôte - Agent - Environnement", alors, c'est... Votre Seigneurie, je m'aperçois que c'est peut-être plus correct sur le plan stylistique d'avoir dit "modèle".

Me JOYAL:

Q- On va y arriver tantôt au modèle "Hôte - Agent - Environnement". Toujours à la même page, au deuxième paragraphe, vous parlez de... "justification que propose la santé publique comme spécialité médicale". Pourriez-vous expliquer ce que vous avez voulu dire quand vous parlez de justification que propose la santé publique.

R- O.K. Le mot "justification" ici, je l'entends... dans

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mon esprit, c'est un synonyme de "explication", si vous voulez, d'explication scientifique sur laquelle s'appuie cette intervention-là, beaucoup. Et donc, une intention pûrement descriptive ou analytique que j'aie ici, de présenter qu'est-ce que c'est qui est son... le fondement empirique de ce type d'interventions-là.

Q- A la page trois (3) de votre rapport, pourriez-vous me dire qu'est-ce que c'est la santé publique.

LA COUR:

Vous pensez pas qu'il l'a déjà dit un peu, là?

Me JOYAL:

Il y a peut-être d'autre chose à dire, Votre Seigneurie, je suis un étudiant qui en oublie.

R- Votre Seigneurie, la santé publique au sens où je vais l'utiliser dorénavant -- et je vous promets de m'en tenir à ça -- c'est au sens de la spécialité médicale, ou... enfin, d'une forme, une partie spécialisée de la pratique médicale; et pour l'essentiel, chaque référence que je veux faire à cette discipline-là, vont être... devraient être comprises dans ce sens étroit, étroit du terme-là. Maintenant, la description que je fais ici, de l'évolution historique d'un certain nombre d'instruments qui sont encore d'utilisation courante en santé publique, procède d'horizons beaucoup plus vastes que les seuls horizons de la profession médicale. Dieu

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merci! S'il avait fallu en être l'unique associé, on serait encore à l'âge des cavernes. Mais dans les faits, je présente d'autres exemples d'instruments d'intervention en santé publique, j'ai parlé, je pense, de la quarantaine, de l'isolation, du contrôle environnemental, des surveillances épidémiologiques. Bien, c'est autant d'instruments qui bien que mis au point il y a quatre (4), cinq (5) ou six (6) siècles, continuent à être utilisés de façon courante en mil neuf cent quatre-vingt-dix (1990), par mes collègues spécialistes.

LA COUR:

On va faire un petit "break" de dix (10) minutes.

SUSPENSION DE LA SÉANCE

REPRISE DE LA SÉANCE

FERNAND TURCOTTE, sous le même serment.

INTERROGÉ PAR Me CLAUDE JOYAL,

Pour l'intimé :

Q- À la page quatre (4) de votre rapport, docteur Turcotte, au deuxième paragraphe, la troisième ligne, vous mentionnez l'ergotisme et le saturnisme.

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R- Oui, Votre Seigneurie. C'est... l'ergotisme, de fait, c'est une... c'est une forme d'intoxication qui survenait, qui était d'origine alimentaire. Essentiellement, c'était une moisissure, ou un champignon qui poussait dans certaines céréales, surtout le seigle, et qui finissait par donner des... enfin la manifestation de l'ergotisme, c'est que c'est un... le produit est toxique à très petites doses, et donne des manifestations vasculaires périphériques, qui entraînent la gangrène, et donc entraînaient l'obligation d'amputer les gens, et donnaient aussi, bien sûr, des convulsions, et caetera.

Et ça apparaissait bien sûr en épidémie, dans des populations, avec la particularité cependant que personne faisait de la fièvre. Les gens devenaient malades brutalement, sans avoir senti venir ça, étaient malades de façon terriblement typique. Il y en a qui avaient que des douleurs; il y en a d'autres qui avaient les bouts des doigts qui devenaient noirs; il y en a d'autres que c'était toutes les jambes qui devenaient noires, et caetera. Le polymorphisme, si vous voulez, de la manifestion, a rendu difficile l'identification correcte du principe de l'agent causal, ou du facteur de risque essentiel dans ce cas-ci, qui était cette moisissure-là.

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LA COUR:

Q- Ça a disparu? Est-ce que ça existe encore?

R- Ça existe encore. C'est-à-dire que techniquement... en fait, aujourd'hui on a réussi à prévenir l'ergotisme, mais tous les éléments pour avoir d'autres épidémies d'ergotisme seraient là. Mais aujourd'hui, d'abord on protège avec grand soin les céréales contre la contamination par les champignons. On utilise toutes sortes de préparations, surtout à base de métaux lourds, pour empêcher ça d'arriver, mais ça arrive encore. Mais des épidémies comme on a vues, affectant des populations, des régions entières, des provinces entières, comme on a vu en Europe, non, ça aujourd'hui on connaît plus ça.

Le saturnisme, lui, de fait, c'est la façon littéraire pour décrire l'intoxication chronique au plomb, intoxication chronique au plomb qui était très très répandue dès l'Antiquité, surtout parce que les gens avaient développé l'habitude d'utiliser des sels de plomb pour sucrer leur vin. Les sels de plomb sont sucrés, et ça transforme le plomb en forme organique et ça le rend très facilement assimilable. ... Ou avaient découvert que... les Romains avaient découvert que, en scellant les cruches dans lesquelles ils faisaient vieillir le vin avec des bouchons en plomb, qu'il avait

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un meilleur goût -- mais dans les faits c'est qu'il se chargeait en plomb, et ça finissait par donner, si vous voulez, les symptômes... enfin ou les problèmes d'intoxication chronique. Ça rendait les gens stériles.

Et il y en a qui ont prétendu que le déclin de l'empire romain, c'était dû à une intoxication chronique de l'élite par le plomb, puisque il y avait que l'élite qui avait le droit de consommer du vin à l'époque et qui, elle, donc était frappée sélectivement d'un saturnisme qui a détruit sa vitalité ou sa force de reproduction.

22/0139 On a observé, encore au siècle dernier, en Angleterre, par exemple, où les guerres franco-anglaises rendaient terriblement irrégulier l'approvisionnement en vin de l'empire. Alors quand il y avait pas de vin, les Anglais, qui étaient écoeurés de boire de la bière, se faisaient du cidre, et ils écrasaient leurs pommes dans des meules où les pierres étaient scellées avec des joints au plomb; et encore là, l'acidité du jus de pommes fixait suffisamment de plomb pour contaminer au plomb le cidre, et entraînait encore là des épidémies de saturnisme dans la population.

Me JOYAL:

Q- À la même page, au bas de la page, vous parlez de taux de mortalité. Pourriez-vous nous expliquer comment une

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société peut être capable de déterminer son propre taux de mortalité.

R- C'est une idée qui a été pour la première fois formulée en santé publique par -- au début du siècle ou enfin dans les années vingt ('20) -- par Biggs, qui, réfléchissant sur ce que les connaissances disponibles nous apprenaient à propos des maladies, nous disait finalement: pratiquement toutes les maladies et la mortalité prématurée qu'on a observées dans les populations humaines sont liées, sont expliquées par quatre (4) facteurs.

Il y a ou bien l'occupation; il y a ou bien des conditions générales de vie (l'habitat, par exemple; l'alimentation, et caetera); il y a ou bien les styles de vie -- sédentarité étant un exemple de ceci; ou bien il y a les pratiques culturelles. Pratiques culturelles... la plus manifeste, je pense -- c'est celle qu'on voit le moins -- c'est la sexualisation des rôles dans la société.

Le fait, par exemple, que la pratique de certains sports est systématiquement interdite aux filles, interdite spontanément aux filles. Il y a pas de joueurs féminins dans la Ligue nationale de hockey. Mais c'est pas écrit dans la biologie, cette affaire-là, c'est simplement le reflet d'une pratique de société.

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Ça a rien à voir avec le potentiel, potentiel athlétique des filles. Et la preuve, c'est qu'aux Olympiques, les nageuses féminines ont fini par avoir des meilleures performances que les nageurs masculins, à partir du moment où on a, si vous voulez, tiré des athlètes de pointe du même "pool", ou du même cadre d'échantillonnage qu'on tire les athlètes masculins.

Alors dans ce contexte-là donc, si on accepte ça, que au-delà... que au-delà des limites qui sont fixées quelque part par la biologie, et qu'on connaît pas, qui font partie du connaissable plutôt que du connu, pour l'essentiel les sociétés ont la capacité de décider qu'est-ce que va être la longévité moyenne des gens, en décidant d'adopter ou pas des interventions qui visent à prévenir certaines épidémies qui tuent le monde, ou bien donc à les laisser aller.

Et c'est à ça que Biggs... c'est à ça que Biggs référait quand il a émis cette idée-là, en disant que finalement une société donnée a la possibilité d'intervenir d'une manière tout à fait efficace dans la mortalité prématurée qui l'affecte. À l'intérieur bien sûr des limites qui sont fixées par la biologie. Mais encore là, les limites de la biologie, il faut se comporter à leur égard comme on se comporte face à la loi naturelle. C'est toujours incomplètement connu. Ça

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fait partie du domaine du connaissable, et on peut jamais présumer qu'on a atteint... qu'on a atteint, si vous voulez, la limite de ce qui est faisable.

Et on est témoin d'un exemple contemporain de ceci. Pendant très longtemps on a cru que même en étant très zélés en matière de protection maternelle et infantile, on serait incapables d'abaisser le seuil de la mortalité infantile en bas de dix (10) pour mille (1,000). Et en mil neuf cent soixante-dix-sept (1977), soixante-dix-huit ('78), je pense, les Finlandais sont passés à neuf point deux (9.2). Trois (3) ans après les Suédois sont passés à huit point quatre (8.4); et là on est rendus autour de sept point un (7.1). Et même pour nous, ça reste un phénomène qui est difficile à comprendre, puisque on avait l'impression que la limite naturelle infranchissable était autour de dix (10) pour mille (1,000) -- mais dans les faits, on l'a défoncée de presque vingt-cinq pour cent (25%) aujourd'hui.

LA COUR:

Q- Mais ça c'est par le bas. Par le haut, on a une bonne idée.

R- Bien par le haut, par le haut, on pense maintenant en termes de cent (100) ans, ce qui est déjà deux (2) fois plus élevé que ce qu'étaient les estimations que faisait Voltaire, par exemple, ou que faisait Rousseau il y a

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pas si longtemps que ça. Dans l'histoire de l'homme finalement, ces gens-là sont beaucoup plus près de nous autres que l'homme de Cromagnon ou ces choses-là, mais pour eux autres, leur horizon normal de longévité, c'était autour de cinquante (50), cinquante-cinq (55) ans, soixante (60) ans; mais nous autres, à cinquante-cinq (55) ans, on a l'impression qu'on ne fait que commencer à vivre. On peut encore anticiper sur trente (30) ans de vie active, et puis... dépourvue d'infirmités incapacitantes.

Me JOYAL:

Q- Voulez-vous tourner à la page cinq (5) de votre rapport. Docteur Turcotte, je vous ai demandé pour vous ce qu'était un modèle et quels étaient les outils de la santé publique. Pourriez-vous nous expliquer le fonctionnement du modèle que vous commentez à la page cinq (5), et dans un deuxième temps nous illustrer avec un exemple.

R- O.k. Alors le modèle qui me semble le plus adapté ou le mieux... le mieux convenir, si vous voulez, au problème qui nous concerne, c'est le modèle présenté par cette espèce d'aire à trois (3) sommets qu'on appelle l'agent, l'hôte et l'environnement. Et c'est un modèle qui s'est révélé particulièrement efficace pour comprendre les maladies infectieuses des deux (2) variétés, à la fois

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les maladies aiguës et les maladies chroniques, et qui dans le passé a permis aussi d'élucider des problèmes qui étaient, pas liés aux agents infectieux, mais des problèmes par exemple liés à ce qu'on appellerait aujourd'hui "styles de vie", mais des problèmes de diète, le scorbut étant le prototype du problème ancien lié à la diète, c'est-à-dire d'une carence systématique dans une vitamine qui présente toute une série de difficultés par la suite.

Alors ce qui est intéressant avec un modèle comme celui-ci, c'est qu'il nous permet d'identifier raisonnablement rapidement si, de fait, le problème de santé qui nous intéresse est réparti au hasard dans une population. Parce que déjà le fait de répondre à cette question-là nous permet de faire l'économie de recherches inutiles. Si le problème est réparti au hasard, ça donne rien de perdre de la sueur dessus, on pourra pas le résoudre. Faut vivre avec. Il fait partie de la calamité que le Bon Dieu nous envoie, si vous voulez. Mais à partir du moment où, par ailleurs, on identifie que le problème n'est pas réparti au hasard dans la population, là c'est important d'expliquer pourquoi il est réparti comme il l'est.

Et l'explication, ou la réponse à ce pourquoi-là vient précisément du modèle à trois (3) pôles, mon

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modèle triangulaire ici. Parfois, c'est des caractéristiques de l'hôte qui vont expliquer cinq (5), dix (10), quinze (15) ou vingt-cinq pour cent (25%) du problème. Parfois, c'est des caractéristiques de l'agent, quand on en identifie un, ou quand le déroulement du problème, tel qu'on l'observe dans la population, fait penser ou suggère la possibilité que ce soit un agent causal identifiable.

LA COUR:

Q- L'hôte étant la victime... la victime infectée.

R- C'est ça, le patient.

Q- L'agent étant l'agent pathogène.

R- C'est ça.

Q- Puis l'environnement, c'est le mécanisme de transmission.

R- Pas nécessairement. L'environnement, si vous voulez, c'est un petit peu cette espèce de zone grise dans les... que partagent en commun l'hôte et l'agent, et qu'on définit du mot d'"environnement", faute de pouvoir lui donner une définition plus précise. Mais c'est commode sur le plan de la pensée que d'avoir des idées claires et des idées précises, mais aussi de se garder une marge de manoeuvre pour les recombiner à l'intérieur d'un certain ensemble. Et c'est essentiellement ça que vient faire le rôle de l'environnement ici.

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Parfois, c'est l'environnement qui va donner la clé, qui va donner la clé aux mécanismes de transmission, qui va expliquer le mécanisme d'action, mais parfois c'est l'environnement qui va nous suggérer une piste à explorer en l'absence d'une connaissance plus précise du mécanisme d'action. Et dans l'exemple que j'utilise, que... enfin, que j'utiliserai tout à l'heure -- pour répondre à la deuxième partie de la question, Votre Seigneurie -- on verra que ça s'applique très très bien et ça permet d'intervenir d'une manière très efficace dans un contexte de connaissances très incomplètes du mécanisme.

C'est ça qui est fondamental, et qui est tellement intéressant -- pour les gens de santé publique en tous les cas. Puisque à partir du moment où on a identifié qu'un problème est pas réparti dans la population au hasard, et qu'on a identifié d'autre part des facteurs de risque qui expliquent une partie de cette répartition-là, et qu'à l'intérieur de ces facteurs de risque-là on trouve des facteurs de risque qui se prêtent à modification, surtout quand ces facteurs de risque qui sont modifiables expliquent une partie importante du problème, bien là on a réuni les ingrédients qui permettent de penser à concevoir une intervention, ou la mise au point d'un programme de

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modification de ces risques-là.

Et c'est dans ce contexte-là que si on prend -- et j'aimerais tout de suite introduire l'exemple que vous me proposiez tout à l'heure -- si on examine, on réfléchit trente (30) secondes au problème posé par la mortalité prématurée qu'on est obligé d'endurer dans notre société à cause des traumatismes, des traumatismes routiers, o.k.? De fait, de parler de la mortalité accidentelle c'est en apparence beaucoup plus simple que ça ne l'est en réalité, puisque il y a un grand nombre de facteurs qui interviennent.

On sait que, bon, bien ultimement la cause, c'est un échange brutal d'une trop grande quantité d'énergie entre un corps humain puis un corps... un corps inerte. Mais quand on a dit ça, on a tout dit puis on n'a rien dit. Dans les faits, si on examine le problème de la mortalité prématurée par accident avec le modèle "Hôte - Agent - Environnement", bien tout de suite on est portés à identifier un certain nombre de facteurs qui se prêtent à modification, et qui sont susceptibles d'apporter chacun leur petite partie de réponse à l'ensemble du gros problème.

Prenons l'hôte, par exemple. Et l'hôte, de fait, il y a un certain nombre de ses attributs... on sait par exemple que les accidents, la mortalité accidentelle

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frappe surtout les hommes; elle les frappe surtout entre quinze (15) et trente (30) ans; et qu'elle les frappe surtout très fréquemment en association avec l'alcool, par exemple, l'utilisation d'alcool; très fréquemment en situation d'utilisation, par exemple, d'illégalité -- absence de permis de conduire ou n'importe quoi d'autre. Bon.

On peut pas changer le sexe des hommes, à moins de décider que le fait d'être un homme de moins de trente (30) ans c'est à priori un critère d'exclusion de permis de conduire, puis donc qu'il devrait plus conduire -- bien on sait que ça a pas de sens de penser en ces termes-là. Alors on a introduit plutôt des modifications, ou des éléments de programme, qui visent essentiellement à modifier l'hôte. On oblige maintenant les gens à détenir des permis de conduire qui sont restrictifs, qui ont tendance à être établis en fonction de certaines classes de véhicules moteurs. Donc on a limité le droit auparavant universel à conduire n'importe quoi, à partir du moment où on avait réussi son premier test de conduire.

Deuxièmement, on force les nouveaux conducteurs à suivre un cours dans les écoles de conduite, puis à le passer ce cours-là. S'ils réussissent pas... il suffit pas d'y aller, il faut encore réussir l'épreuve pour

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pouvoir obtenir son permis de conduire. On a introduit le système des points d'inaptitude, de manière à ce que la commission d'offenses, si vous voulez, garde quelque part une trace dans une mémoire institutionnelle, de telle sorte qu'on puisse, en tous les cas, restreindre le droit de conduire pour les plus imprudents, ou les plus maladroits, ou les plus fréquemment en infraction, avec un certain nombre de contraintes.

On a introduit une nouvelle offense: la conduite avec facultés établies...

Q- Affaiblies.

R- Affaiblies. Facultés établies... facultés affaiblies. Et on a finalement, et c'est la dernière innovation, introduit, rendu obligatoire le port de la ceinture. Bon. Chacune de ces mesures-là prise isolément est pas capable de résoudre à elle seule le problème de mortalité accidentelle, mais si on prend l'ensemble des mesures qu'on a identifiées tantôt puis qu'on les met à côté de celles qu'on a pensé introduire dans l'agent -- et puis ici l'agent, par commodité, là, on va décrire tous les facteurs qui se rapportent, qui concernent les véhicules -- on a commencé à introduire, par exemple, l'obligation pour les véhicules de pouvoir tolérer des chocs minimaux. Donc on a eu des normes de sécurité pour la solidité des pare-chocs; pour la solidité de la

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cabine; pour les caractéristiques de fabrication des volants, qui doivent être maintenant construits dans le sens qu'ils sont flexibles. La même chose pour les tableaux de bord. Il doit plus y avoir, si vous voulez, d'objets qui font protusion et qui résistent à un choc qui est prédéterminé. On introduira bientôt l'obligation de conduire avec les phares allumés. Bref, il y a toutes une série... si vous voulez, on encadre, par exemple, de façon beaucoup plus serrée l'état mécanique, ou la compétence mécanique des véhicules quand ils ont atteint un certain âge; une inspection est obligatoire pour renouveler les permis.

Bref, encore là c'est toute une série de mesures qui portent spécifiquement sur l'agent, cette fois-ci, qui, pris isolément sont probablement pas capables de résoudre une très grande partie du problème, mais si vous les mettez côte à côte par rapport à ce qui a été maintenant envisagé comme intervention sur l'environnement général -- et là, de fait, on a réduit les limites de vitesse, on a introduit la ligne pleine sur le bord droit de la chaussée, qui fait partie maintenant obligatoirement du paysage; les passages cloutés qui sont identifiés différemment; les feux de circulation qui sont synchronisés; la normalisation de la signalisation, sont autant de modifications de

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l'environnement qui visent essentiellement toutes le même objectif: réduire significativement la mortalité prématurée qui est évitable.

Et de fait, on observe déjà une réduction sensible de ce type de problème de santé-là, tout en étant à peu près aussi ignorants qu'on l'était auparavant sur ce qu'est l'histoire naturelle véritable de cette calamité-là. Bon, bien il y a... on est probablement abonnés pour une grande série de débats sur quel est le facteur causal précipitant, le type de personnalité, quelles caractéristiques raciales prédisposent aux accidents, et caetera; mais tout ça finalement, c'est relativement secondaire dans la perspective de santé publique si déjà, avec une série de mesures qui ressemblent à celles que je décris, permettent de réduire de vingt-cinq (25), de trente (30), de quarante (40) ou de cinquante pour cent (50%) le problème. O.k.?

C'est ça qui est au fond le genre de... de mécanismes de prise de décision qu'utilisent les spécialistes de santé publique, avant que d'identifier... je veux dire, quand ils choisissent les problèmes sur lesquels il y a lieu d'intervenir.

Me JOYAL:

Q- On va revenir un peu plus tard au modèle "Hôte - Agent - Environnement". A la page six (6) de votre rapport,

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vous référez à John Snow. Pourquoi est-ce que vous avez décidé de référer à l'exemple classique de John Snow?

R- Ben parce que l'exemple... j'aime l'utiliser pour trois (3) raisons: c'est que John Snow, par son action, a démontré en mil neuf cent... en mil huit cent trente-deux (1832), ce que la communauté médicale a accepté de reconnaître comme vraiment un fait établi, qu'en mil neuf cent dix-huit (1918), mil neuf cent dix-neuf (1919), à propos du choléra. Donc, ça veut dire qu'il avait pratiquement quatre-vingts (80) ans d'avance sur la communauté scientifique. C'est pas négligeable. La deuxième, la deuxième des... le deuxième motif, c'est que l'exemple de John Snow pointe une intervention extrêmement simple, pour résoudre un problème terriblement complexe. Il est parti avec sa clef anglaise puis il a dévissé la poignée de la pompe. Et le troisième motif... enfin, le deuxième motif, c'est... je trouve toujours ça ironique, que pour résoudre un problème aussi complexe, un moyen aussi simple se soit révélé d'une aussi grande efficacité. Et quand... enfin, dans ma spécialité, quand on est porté à se prendre pour d'autre, on réfléchit toujours à l'exemple de John Snow, puis ça nous ramène sur la terre.

Mais il y a...

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LA COUR:

Ça vous arrive jamais ça, dans votre milieu...

R- Ouf, j'ai eu très souvent des crises de doute, Votre Seigneurie. Et jamais autant que dans les deux (2) dernières semaines, je vais vous avouer. Mais j'aimerais ajouter que dans le cas, dans le cas de l'expérience de John Snow, il y avait, il y a un exemple, une leçon additionnelle qu'il nous faut tirer sur laquelle, en tout cas, nous, devons réfléchir, les gens de la santé publique: C'est que John Snow, quand il a identifié que c'était la pompe de Soho qui était vraisemblablement l'origine de la cause, il y avait d'un côté la certitude qu'il avait dans la validité de sa déduction, il y avait de l'autre côté l'inconfort épouvantable qu'y créait pour tous les gens du quartier, et qui fait qu'il aurait jamais osé sortir dehors puis dire: "On va fermer la pompe de Soho... de Broad Street." puisqu'il se serait probablement fait... peut-être pas lynché, mais il aurait connu un mauvais quart d'heure.

Il a fallu qu'il se rende le soir, à l'insu de tout le monde, pour faire son opération, parce que c'était carrément pas acceptable pour les habitants du quartier de Soho que de se faire priver de leur point d'eau. Or, il a résolu cette difficulté temporaire en se rendant

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là, après son quart de travail le soir, puis en dévissant ça en secret. Maintenant, dans le cas d'une opération comme celle-ci, c'était... les bénéfices étaient immédiatement observables; en dedans de sept (7), huit (8) ou dix (10) jours, l'épidémie, si vous voulez, était contrôlée, et les gens, finalement, ont été terriblement... comment je pourrais dire?... soulagés d'être épargnés par la menace que représentait toujours à cette époque-là l'épidémie de choléra.

Alors, c'est la raison pour laquelle, Votre Seigneurie, j'ai introduit cette exemple-là, dont on a dû vous parler, au moins à vingt-cinq (25) reprises depuis... depuis le début de ce dossier-là.

LA COUR:

Pas vingt-cinq (25). Mais quand même, on en a déjà parlé.

Me JOYAL:

Q- A la page sept (7) de votre rapport, au bas de la page, vous parlez d'intervention sur l'environnement. Pourriez-vous nous donner d'autres exemples d'intervention sur l'environnement.

R- Ah oui. Si vous me permettez, Votre Seigneurie, dans la continuité de la mortalité accidentelle, il y a une intervention sur l'environnement qui mérite d'être soulignée, puisqu'on en est des témoins contemporains.

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C'est l'opération nez rouge. L'opération nez rouge, qui a visé essentiellement à faire changer la notion que c'est pas... c'est pas avilissant que de se trouver suffisamment "ébrieux" pour être momentanément incapable de conduire. Ce qui n'était pas le cas il y a juste sept (7), huit (8) ans; il y a personne qui aurait osé reconnaître être assez "paqueté" ou trop "paqueté" pour conduire. L'opération nez rouge a permis, au contraire, de rendre l'idée tout à fait farfelue. Ben oui! C'est parfaitement possible qu'on soit rendu incapable de conduire parce qu'on a pris deux (2) verres de trop. Et au fond, aujourd'hui, c'est devenu un espèce de ce qu'on pourrait appeler un "running joke", si vous me permettez le barbarisme.

C'est un prototype d'intervention sur l'environnement, mais... Un autre type: L'obligation qu'on a faite d'ioder le sel de table, qui est une intervention du XXe siècle, qui a permis de faire, à toutes fins pratiques, éradiquer une maladie de carence, qui est une maladie de la glande thyroïde, qu'on appelait le goître, le goître endémique, et qui était dû au fait que dans certaines régions, surtout, au fur et à mesure où les populations s'éloignaient des littoraux marins, étaient de moins en moins exposés aux quantités d'iode requise pour leur métabolisme, et à ce moment-là,

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on a résolu le problème en disant: "C'est ben simple, on va ajouter de l'iode au sel; comme tout le monde a besoin de consommer du sel, ils vont consommer de l'iode, et puis à ce moment-là, de fait, on résout le problème."

Et aujourd'hui c'est passé dans les moeurs, même si à l'époque -- et quand je parle d'époque, là, je monte au temps de la guerre. Fabia a même raconté que pendant la période d'occupation, la chose la plus précieuse que les familles avaient, dans les territoires occupés, c'était leur quantité, leur inventaire de sel. C'était plus important que tout le reste. Ils préservaient ça avec la dernière énergie. C'était à ça qu'on proposait d'ajouter de l'iode, qui, bien sûr, pouvait être présenté comme un poison virulent, quand c'est pris dans sa forme métallique ou ces choses-là; mais dans le contexte ici, ce qu'on avait besoin, c'était simplement d'ajouter le dosage qui permettait d'assurer une captation moyenne, suffisante, pour empêcher le développement du goître endémique, avec tous les problèmes connexes, qui entraînent l'infertilité, retard de développement psycho-moteur, et puis pauvreté par extension, etc.

Un autre exemple d'environnement que j'aime utiliser, c'est celui que le développement de la

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technologie, dans les meuneries, a eu comme implication pour le monde. C'est que les meuneries sont devenues tellement efficaces, qu'elles ont produit de la farine blanche pour le même prix que la vieille farine brune. Alors les gens se sont précipités sur la farine blanche, jusqu'à ce qu'on s'aperçoive que la farine blanche, qui goûtait meilleur, puis qui donne de meilleurs résultats en cuisine est pas aussi nutritive et manque de principes alimentaires fondamentaux. Alors, on a remédié à ceci en enrichissant à nouveau la farine blanche avec de la vitamine préparée de façon synthétique, plutôt que la vitamine trouvée à l'état naturel dans le son, qu'on éliminait avec de la farine brune. Mais c'est un bel exemple d'intervention sur l'environnement, puisque dans les faits, la diète, c'est l'environnement -- enfin, c'est un élément de l'environnement avec lequel le corps humain est en interaction trois (3), quatre (4) fois par jour.

Q- Quand vous dites qu'on est arrivés à enrichir la farine, est-ce que je comprends que l'intervention était volontaire? Comment est-ce que ça s'est concrétisé dans les faits?

R- Bien, de fait, ces innovations-là sont parfois adoptées tout à fait spontanément. Parfois, il faut convaincre les gens, il faut convaincre... mais normalement...

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c'est-à-dire, dans le cas concret, la farine est enrichie par réglementation; et à ce moment-là ce qui nous appartient, comme spécialistes de la santé publique, c'est de rendre l'information suffisamment pour clairement comprendre, pour que les gens prennent leurs responsabilités.

Alors dans les sociétés, c'est les sociétés qui se dotent spontanément des décisions qu'elles estiment être nécessaires pour résoudre un problème. Si le problème est suffisamment important, il va adopter -- je sais pas, moi -- le règlement ou la solution qui est recommandable. Mais c'est aux sociétés, c'est aux citoyens qu'il appartient de prendre ces décisions-là.

Q- À la page huit (8) de votre rapport, au deuxième paragraphe, vous parlez de maladies débilitantes et de tabagisme. Pourriez-vous expliquer qu'est-ce que c'est.

R- Oui. J'utilise cette expression-là ici au sens étroit que donne le dictionnaire aux deux (2) termes, et "maladie", et "débilitante". Maladie, là, c'est vraiment compris ici au sens d'une altération physiologique durable de la biologie humaine, o.k.? Tous les mots sont importants. C'est une altération physiologique durable -- j'ai pas dit irréversible -- mais elle est durable, de la biologie humaine, et elle est due à l'action d'un facteur extrinsèque, en général.

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Et dans ce cas ici, de fait, je réfère essentiellement à l'altération permanente de la physiologie qui est entraînée par un produit, un élément psychoactif qu'on retrouve dans la cigarette, et c'est essentiellement un insecticide biologique qui s'appelle nicotine, o.k., qui précisément à cause de ses propriétés d'insecticide... o.k., ses propriétés sur le système nerveux central sont aussi les mêmes propriétés qui, à petites doses, donnent l'effet agréable, l'effet de stimulation qu'on retrouve dans la cigarette. Mais dans la mesure où l'organisme développe rapidement le besoin d'avoir cette exposition-là, ou cette alimentation-là continuée, là l'altération physiologique permanente, ou durable plutôt, est produite; et à partir de ce moment-là, on est en présence d'une maladie, à mon point de vue.

LA COUR:

5/0110 Q- Et quand vous parlez d'insecticide, faites-vous une image ou vous parlez... parce qu'effectivement, la nicotine sert dans les pesticides.

R- Non. De fait, la nicotine, sa classification toxicologique c'est un insecticide biologique. Dans un bouquin de toxi...

Q- C'est ça. On la retrouve dans les pesticides aussi.

R- Bien oui, il est classé comme pesticide; et si vous

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prenez n'importe quel bouquin de toxicologie, vous allez le retrouver dans la famille des insecticides, ou des pesticides, si vous voulez, mais c'est un... il est utilisé plus spécifiquement comme insecticide. Enfin, il est utilisé... c'est des dérivés de nicotine pur -- enfin, de nicotine, le prototype qu'on retrouve dans le tabac, de fait, est pas utilisé comme tel parce qu'il est trop violent, et il serait trop difficile à contrôler puis à doser, alors on le modifie.

Alors ça c'est pour le mot "débilitante"... c'est-à-dire le mot "maladie", o.k.? Alors dans mon esprit, de fait, c'est une altération durable de la physiologie humaine et qui se traduit essentiellement par... surtout par des effets sur le système nerveux central, le système circulatoire central, ou le coeur, le système circulatoire périphérique, c'est-à-dire la motricité des vaisseaux, surtout les artérioles.

Le mot "débilitant", lui, vient vraiment du dictionnaire aussi. C'est au sens d'affaiblissant. C'est-à-dire que c'est une maladie débilitante puisque... parce que elle accapare une partie significative de la réserve physiologique que nous avons en biologie, une partie de notre réserve respiratoire, une partie substantielle de notre réserve circulatoire, et une partie aussi circulatoire; et une partie aussi

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importante de notre réserve hémodynamique, c'est-à-dire la fraction de l'hémoglobine qui est immobilisée par le monoxyde de carbone.

Alors, en temps normal, on fonctionne avec... en utilisant peut-être cinquante-cinq (55), soixante (60), soixante-cinq pour cent (65%) de notre potentiel. Quand on a un effort violent à fournir, on peut monter à quatre-vingt-cinq (85%), quatre-vingt-dix pour cent (90%) de notre potentiel. C'est ce qu'on fait quand on fait du jogging. Il est assez rare qu'on soit placés face à des conditions qui mobilisent cent pour cent (100%) de notre réserve physiologique pendant une période de temps prolongée; et pour l'essentiel de notre vie, c'est ça qui est vrai. Jusqu'au jour cependant où on devient malade.

Là là, très souvent, pendant la période de convalescence, on a besoin de toutes notre réserve physiologique. Et c'est souvent à ces moments-là que le prix qu'on a à payer pour avoir laissé s'hypothéquer par une maladie débilitante une partie de notre réserve physiologique, c'est là qu'on le paye. Et c'est pour ça que la mortalité, qu'on associe par exemple à l'exposition à la fumée de cigarette, est démesurément représentée à la fin de la vie, c'est-à-dire après soixante-dix (70) ans; mais sur le plan strictement

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physiologique il y a une explication tout à fait normale à ceci, et c'est là qu'on la retrouve.

Alors c'est ce que j'entendais, Votre Seigneurie, par l'expression "maladie débilitante".

Me JOYAL:

Votre Seigneurie, m'accorderiez-vous cinq (5) minutes? J'ai peut-être pris trop de café sur l'heure du dîner. Ça me permettrait de... ça sera pas plus long que cinq (5) minutes.

LA COUR:

Je suis à l'extérieur.

SUSPENSION DE L'AUDIENCE.

LA COUR:

Vous avez retrouvé vos esprits?

Me JOYAL:

J'ai retrouvé mon sourire.

Q- Alors, on était à la page huit (8), docteur Turcotte. Vous mentionnez que depuis le début du siècle les taux de mortalité ont diminué. Comment situez-vous le taux de mortalité attribuable au tabagisme, par rapport à la baisse des taux de mortalité?

R- De fait, Votre Seigneurie, c'est un des... c'est une des ironies de la situation contemporaine. Nous avons

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réussi, au cours de ce siècle, à le baisser significativement, la mortalité, surtout d'origine infectieuse, beaucoup aussi à cause de... d'améliorations tellement, tellement importantes de nos conditions générales de vie, que, dans les faits, on a pu dans un pays, par exemple, comme le Royaume-Uni, que j'utilise ici dans mon exemple, parce que c'est un pays dont les statistiques d'état civil sont particulièrement fiables pendant la période qui nous intéresse. On a obtenu une réduction de trois (3) pour un (1) de la mortalité.

Ce qui est intéressant, cependant, c'est que pendant la même période, on a vu apparaître, si vous voulez, progressivement les prix de santé à payer pour une exposition au tabac qui est devenue de plus en plus importante à partir surtout de la fin de la Première Guerre mondiale. De sorte qu'il y a une partie du gain qu'on aurait dû obtenir, qui a été neutralisé. Et pour les hommes britanniques, on estime que la perte sèche du gain de mortalité, qui est imputable à la seule exposition au tabac, via la cigarette pour l'essentiel -- puisque c'est la cigarette qui est vraiment le problème -- est de quarante pour cent (40%), presque quarante pour cent (40%).

C'est-à-dire que plutôt que d'avoir une réduction

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qui nous fasse passer de dix-huit (18) à six (6) pour cent mille (100 000) habitants, on serait peut-être passé de dix-huit (18) à quatre (4) pour cent mille (100 000) habitants. Mais chez les hommes on a été empêché de le faire, en bonne partie parce que eux ont commencé, pour des raisons diverses, à peu près au même moment où commençait précisément à s'améliorer les principaux indices de mortalité, à être exposés de façon massive et continue, à un... à des produits, qui à l'époque, enfin, étaient perçus comme vraisemblablement plutôt... tenaient bien de la nuisance plutôt que de la maladie, et qui s'avèrent maintenant avoir été, être terriblement toxiques.

Q- A la page neuf (9) de votre rapport, vous référez à un tableau, qui lui est reproduit à la page dix-neuf (19). Il s'agit d'un tableau tiré de Fielding. Pourriez-vous nous dire qui est Fielding.

R- Jonathan Fielding, c'est un professeur de médecine préventive, Votre Seigneurie, à l'Université de Californie, je pense à Los Angeles. C'est quelqu'un qui... bah est un confrère de classe, donc à peu près mon âge, et qui est devenu particulièrement connu pour ses écrits dans le domaine de l'éducation de la santé. Et il a été... c'est lui qui a écrit le, un chapitre qui s'appelle "Smoking Health Effects and control" dans

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l'édition du volume de Maxcy-Rosenau, et qui est un des manuels qu'on utilise beaucoup dans notre spécialité, qui est un des manuels de base, si vous voulez. Et dans ce chapitre-là, il présente précisément ce tableau qui permet de... qui permet de bien comprendre, au fond, le type de problème particulier que pose à l'intelligence médicale contemporaine, la reconnaissance des effets liés au tabac.

On a ici, sur un graphique qui représente essentiellement ce qui s'est passé depuis le début du siècle, là, une ligne qui décrit en noir l'évolution du nombre de cigarettes produits par année par citoyen âgé de quinze (15) ans et plus.

Q- Pourriez-vous nous dire pour quel pays...

R- Pour les Etats-Unis... aux Etats-Unis. O.K., donc c'est des données américaines ici. Et j'utilise des données américaines en bonne partie parce que j'avais pas, au moment de la préparation, accès aux données qui m'auraient permis de faire la même chose pour le Canada, et deuxièmement les profils ne sont pas tellement différents. Les pays industrialisés se ressemblement à peu près tous sur le plan de cette chose-là.

Alors, on entend souvent l'expression, l'expression d'incrédibilité qui dit: "Vous dites que c'est dangereux le fait de fumer, mais mon grand-père est

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mort à quatre-vingt-quinze (95) ans, puis il a fumé toute sa vie." Il est mort, de fait, en tombant dans la baignoire ou des choses comme ça, et le pire, c'est souvent le cas. Enfin... Mais il reste que l'exposition, si vous voulez, des gens qui sont nés en dix-neuf cent vingt (1920) n'est pas du tout semblable à l'exposition qu'ont connue les gens qui sont nés en dix-neuf cent cinquante (1950), ou qui sont devenus adulte en dix-neuf cent cinquante (1950).

Et ça, ça se traduit très, très bien par ce graphique-ci où on voit que la consommation moyenne passe d'une (1) cigarette, si vous voulez, par semaine, à une (1) cigarette par jour; après ça, à trente (30) cigarettes par jour, avec, si vous voulez... et puis une augmentation de la durée pendant laquelle, la consommation s'est établie. Et je veux dire, essentiellement, ce tableau-là permet ici de montrer que, de fait, c'est pas correct sur le plan strictement des idées, que de comparer l'expérience qu'ont connue les générations de nos grands-parents, ou même de mes parents avec le problème tel que nous le vivons présentement, puisque il y a trop d'autres facteurs qui interviennent, dont notamment celui-ci.

Maintenant, ici c'est une estimation de la consommation moyenne, puisque vous comprennez que dans

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le diviseur -- c'est-à-dire le dividende est composé de la production annuelle totale de toutes les cigarettes faites par les Américains, ça fait... ça tient pas compte de celles qui sont exportées, qui sont consommées à l'extérieur du pays, c'est pas ça qui est l'objet de l'intérêt ici, c'est seulement de voir, de... d'estimer l'ordre de grandeur de l'exposition.

LA COUR:

Mais je ne comprends pas votre idée, là. Vous nous dites... que l'exposition est pas la même, mais ceux-là qui sont nés en quarante ('40) puis qui fument depuis cinquante (50) ans, ça fait cinquante (50) ans qu'y sont exposés.

R- Ah oui, ça, je suis tout à fait d'accord avec vous. Maintenant, vous devez... si on regarde par exemple ce qu'était la consommation moyenne en mil neuf cent quarante (1940), O.K. Mil neuf cent quarante (1940), on se situait à peu près à quelque chose comme à soixante-dix (70) paquets/année. O.K. C'est-à-dire qu'en moyenne, l'ensemble de production de cigarettes divisé par le nombre de citoyens de quinze (15) ans et plus, se situait à une consommation moyenne d'à peu près à soixante et quinze (75)... enfin, arrondissons soixante et quinze (75) paquets/année, c'est-à-dire à peu près un (1) paquet par semaine, ou un paquet et

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quart par semaine.

Si on se reporte, si vous voulez, dix (10) ans après, bien déjà on a déjà doublé à toutes fins pratiques, cette ordre de grandeur-là. Et ça, ça reflète, donc, une augmentation relativement... très rapide de la quantité d'utilisation du produit par fondamentalement une population dont les autres indices démographiques ne changeaient pas aussi vite. Donc, ça traduit une augmentation des usagers, puis une augmentation de l'utilisation... de l'intensité de l'utilisation par les usagers, à l'intérieur d'intervalles de temps qui sont très courts, et qui, néanmoins, vingt (20) ans, vingt-cinq (25) ans après, se manifestent déjà par des élévations des problèmes de santé qui sont ceux qui nous intéressent.

Q- Alors, on devrait suivre... on devrait pouvoir suivre à partir de mil neuf cent (1900), qui est le point de départ, une évolution proportionnelle des problèmes de santé avec la consommation, non?

R- Avec le décalage d'à peu près de vingt (20) ans, dont... le docteur Doll vous a dit qu'il fallait, avec lequel il fallait compter, puisque de fait, le pouvoir -- pour certains problèmes de santé expliqués par l'exposition au tabac, il y a un délai de l'attente d'une vingtaine d'années. Mais il est sûr qu'on va observer un

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parallélisme -- je veux dire, si on observait pas ça, on aurait raison de douter de la validité et du sérieux de la preuve épidémiologique qui a été faite.

Me JOYAL:

Q- Dans ce tableau-là, vous définissez le fumeur moyen comment, docteur Turcotte?

R- C'est un fumeur... c'est un fumeur statistique au fond. C'est une créature... c'est une créature théorique qui est composée, comme je vous ai dit ici, c'est le... c'est essentiellement le quotient d'une division du nombre total de cigarettes produit par le nombre total de citoyens âgés de quinze (15) ans, et plus et puis le dividende qu'on obtient c'est ce que nous donne le fumeur moyen, o.k.? Mais c'est à prendre entre guillemets. C'est essentiellement une estimation de la tendance centrale pour essayer de mesurer, de rendre facilement comparable l'exposition entre deux (2) époques, ou trois (3), ou quatre (4) époques, ce que ce tableau-là permet de bien faire.

Q- Mais le tableau ne distingue pas cigarette filtre, à bout filtre...

R- Pas du tout. Non non. C'est toutes les cigarettes ensemble. Mais ce ne sont que les cigarettes. Ça tient pas compte des autres formes de tabac. Pour l'instant, ici là, c'est la cigarette qui nous intéresse.

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Q- Vous parlez, à la page dix (10) de votre rapport, que:

"Les interventions de santé publique requises pour diminuer la mortalité prématurée due au tabac est en retard d'une génération."

Qu'est-ce que vous avez voulu dire?

27/0056 R- Alors, Votre Seigneurie, ce que j'ai voulu dire ici, c'est que les informations requises par la pratique correcte de la santé publique, pour mettre en place, ou c'est-à-dire pour encourager les sociétés à faire face au problème du tabagisme, elles sont vraiment disponibles depuis dix-neuf cent cinquante-quatre (1954). À la rigueur, on peut... on pourrait argumenter que... bien en cinquante-quatre ('54), il y avait juste l'étroite communauté des spécialistes de santé publique qui connaissaient le problème et puis que, bon bien ils ont... c'est pas suffisant qu'eux autres connaissent le problème pour que ça se traduise par une offensive sur ce problème-là.

Alors à la rigueur on pourrait dire que, bon, bien la parution, la publication en soixante-quatre ('64) du premier rapport du Chirurgien général, qui est au fond l'analogue de notre Ministre de la Santé à nous... euh, le Ministre de la Santé américain aurait dû suffire pour déclencher l'espèce de mobilisation que les pays maintenant connaissent, les uns après les autres,

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surtout sous... enfin, en particulier parce qu'ils y sont fortement encouragés par l'Organisation mondiale de la santé sur le tabac.

De telle sorte que si ça avait été le cas, les gens de notre génération, par exemple, Votre Seigneurie -- enfin, ma génération puis la vôtre -- auraient probablement échappé à la... aux prélèvements de mortalité prématurée qu'on va connaître. Moi, pour avoir été fumeur pendant très longtemps, pour avoir été exposé à la fumée de mes parents aussi, et caetera, je veux dire, j'encours une augmentation substantielle d'un grand nombre de risques de maladies chroniques, qui étaient parfaitement évitables. Parfaitement évitables en cinquante-quatre ('54), au moment où moi, je sortais, si vous voulez, de ma communion solennelle, enfin, ou presque.

Et ça, jusqu'à un certain point, c'est difficile à justifier, a posteriori, vis-à-vis les citoyens de ma société, dire "bien, de fait, on connaissait les faits, mais on n'en a pas parlé" ou... on n'en a pas parlé parce que finalement, on savait pas comment faire, ou on n'osait pas comment faire, ou... enfin, il y a un certain nombre de prétextes qu'on peut utiliser, mais il reste que depuis cinquante-quatre ('54), depuis la parution des premières études de Doll, et des auteurs

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américains, on avait tout ce qu'il fallait pour intervenir d'une manière efficace sur ce problème-là. C'est ça que je voulais dire.

Q- Pourriez-vous donner des exemples d'intervention de santé publique qui sont analogues à celles examinées par le Tribunal?

R- Bien moi, Votre Seigneurie, j'avais l'impression que je vous ai cassé pas mal les pieds tout à l'heure avec la considération du problème de mortalité accidentelle, et que c'est une belle illustration, du type d'intervention...

LA COUR:

Q- Non, vous m'avez pas cassé les pieds. Vous avez expliqué votre point de vue, et je l'ai noté d'ailleurs fort bien.

Me JOYAL:

C'est moi.

LA COUR:

Vous êtes pas pour rire de moi, maître...

R- Maintenant, j'ai parlé des exemples... par exemple, d'interventions sur certains produits alimentaires, par exemple. Bon, on pourrait continuer. Le fait, par exemple, d'inciter maintenant les fabricants qui utilisent des additifs dans la fabrication des produits surtout alimentaires transformés, bien c'est un exemple

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d'intervention de santé publique qui vise à aider les citoyens à mieux prendre les décisions qui les concernent, en connaissant, de fait, quand un additif entre dans la fabrication d'un produit qu'ils utilisent.

Le fait, par exemple, de... je sais pas, moi... d'imposer un certain nombre de caractéristiques aux matériaux, par exemple, qui sont utilisés dans la fabrication des meubles pour enfants, des appareils de sécurité qui sont destinés aux enfants, des normes de sécurité pour les berceaux, et caetera, tout ça, sont autant d'interventions de santé publique qui portent sur des éléments qui contribuent d'une manière significative -- sans toutefois expliquer tout le problème -- mais des problèmes de santé publique qui sont bien connus. Et ça c'est des exemples tirés, au fond, de l'actualité, de l'actualité récente; et il y en aura d'autres, j'imagine.

Peut-être que le prototype, le prototype du programme... enfin, il y en a trop de prototypes pour que je commence à ce moment-ci de la journée à m'embarquer.

Me JOYAL:

Q- Pourriez-vous retourner à la page cinq (5) de votre rapport, le modèle "Agent, Hôte et Environnement", et nous expliquer comment le programme compréhensif de la

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lutte contre le tabagisme s'insère dans ce modèle-là.

R- Bien, je pense, Votre Seigneurie, que la meilleure façon de répondre à cette question-là, c'est de revenir précisément à l'énoncé des éléments que l'O.M.S. recommande aux pays membres d'adopter pour enfin... les principes que... recommande d'utiliser pour à chaque État membre, pour qu'il organise chez-lui, la solution du problème posé, ou des problèmes de santé posés par le tabagisme. Mais on les retrouve très bien à la page quatorze (14) et le début de la page quinze (15). On a par exemple un ensemble de mesures qui visent à assurer la protection efficace des non-fumeurs. Ça, c'est vraiment un accent sur l'environnement. Maintenant, mesures efficaces, une mesure qui assure la protection efficace, ici, c'est laissé... y a une assez grand marge de latitude qui est laissée aux États, mais de fait, ce qui est important, c'est d'envisager déjà, comme élément partie de la solution, une action à ce niveau-là.

Il y a deuxièmement des mesures encourageant l'abstention du tabac, de manière à protéger, à empêcher le recrutement de nouveaux fumeurs -- et les nouveaux fumeurs ça va être nécessairement des jeunes. En tout cas, les études menées en Amérique, et dans la plupart des pays industrialisés, montrent que les gens commencent à fumer à l'adolescence, que c'est rare qu'on

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commence après vingt-cinq (25) ans, et que des gens qui commencent à l'adolescence, à part de ça, c'est chez-eux qu'on trouve la plus grande... la plus grande partie de ceux qui ont beaucoup de difficulté à s'arrêter. Alors, c'est un élément clef du programme de prendre les moyens qu'il faut pour empêcher que les jeunes commencent à fumer.

D'abord, les jeunes qui commencent à fumer pour toutes sortes de motifs qui ont souvent, pas beaucoup à voir avec la pharmatologie propre à la fumée de cigarette, et ça, ça cause un problème particulier auquel il faut... auquel il faut s'adresser.

Il y a, troisièmement, des mesures qui visent à assurer que le bon exemple donné par les professionnels de la santé, et... bon bien, vous savez... je peux vous assurer, Votre Seigneurie, que c'est extrêmement difficile à convaincre... à convaincre les médecins fumeurs de ceci, mais on y arrive. Puisque aujourd'hui, de fait, au Canada, je pense que c'est moins de quinze pour cent (15%) des médecins qui sont fumeurs. Aux Etats-Unis, c'est en bas de dix pour cent (10%) maintenant.

Et... ben ça, de fait, c'est un contraste démarqué par rapport à ce que c'était il y a... il y a vingt-cinq (25) ans. Et je serais tenté de dire que si on réussit

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à le faire dans la profession médicale, ben rapidement on va arriver à le faire dans la plupart des professions libérales. Mais il fallait commencer quelque part, et puis, bon ben c'est avec cette profession-là qu'on... c'est toujours plus facile de faire le ménage devant son propre jardin...

LA COUR:

Surtout que ça paraît mal.

R- Ça paraît mal.

Me JOYAL:

Q- Je vous arrête ici avant que vous continuiez, docteur Turcotte. L'O.M.S. parle de mesures; elle ne donne pas les moyens.

R- Elle parle de mesures, c'est ça, oui. Ben... oui.

Q- Alors qui décide des moyens, des mesures à prendre, des précisions, parce que ça... elle dit de prendre des mesures en regardant un objectif, mais qui décide?

R- Ça appartient, ça appartient aux États membres de faire, de prendre ces décisions-là, à l'intérieur de leur propre société, de leur propre juridiction, de voir qu'est-ce qui est faisable, qu'est-ce qui est acceptable par leur propre population. Mais de fait, la santé publique est au service des hommes, et non pas les hommes au service de la santé publique. On est là pour essayer d'identifier les pistes, pour s'assurer que

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l'information est comprise d'une manière correcte, et puis après ça, pour aider les gens à réaliser qu'est-ce qu'ils ont décidé de réaliser. Alors, c'est dans ce cas-là... c'est là que l'O.M.S. par exemple, perd pas trop d'énergie à définir des moyens; peut en fournir des listes d'exemples de moyens, mais ce qui convient de faire à l'intérieur d'une juridiction donnée relève d'abord de la souveraineté de cette juridiction-là qui, elle, n'est qu'une extension de la souveraineté des particuliers.

Q- Vous pouvez poursuivre votre examen des mesures ou des recommandations de l'O.M.S.

R- O.K. Quatrièmement, des mesures qui visent l'élimination progressive de tous les incitatifs, de quelque nature qu'ils soient, qui entretiennent ou font la promotion de consommation du tabac. Et encore là, c'est une rubrique qui ici, de fait, qui s'adresse directement à identifier, ou s'emploie à identifier l'environnement. L'environnement étant défini encore là, avec comme la zone grise, dans laquelle interviennent toutes sortes de facteur, parfois des facteurs culturels, parfois des facteurs de préférence personnelle, parfois, si vous voulez, des facteurs d'opportunité, et qui peuvent avoir une influence sur une prise de décision.

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Me POTTER:

Objection, Votre Seigneurie à la dernière réponse. Ce témoin n'a pas l'expertise pour dire quelle influence ces promotions peuvent avoir.

LA COUR:

Sous réserve.

R- Le cinquième item, des avertissements sur les emballages des produits de tabac, qui rappellent les problèmes de santé causés par sa consommation, et qui, au fond, s'inscrit dans la continuité de la responsabilité qu'ont les États, d'aider les citoyens à prendre une décision responsable. Et pour prendre une décision responsable, il faut avoir accès à l'information, l'information qui est nécessaire pour le faire; et il y a cet élément-là du... de la recommandation de l'O.M.S., vise ça essentiellement.

Sixièmement, l'organisation de programmes d'informations et d'éducation, y compris le programme destiné à ceux qui veulent rompre l'habitude, avec la participation des professionnels de la santé et des moyens de communication, qui, au fond, est une façon de rappeler que les personnes, les personnes qui souffrent présentement de tabagisme ont besoin d'aide, et ont tellement besoin d'aide, qu'aux États-Unis, maintenant, on estime que il y a onze pour cent (11%) des compagnies

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d'assurance, d'assurance maladie, qui acceptent de rembourser les réclamations qui sont... qui leur sont présentées, pour le traitement de la dépendance à la nicotine.

Et c'est un des objectifs du plan décennal des Américains, que de monter à quatre-vingt-cinq pour cent (85%), la proportion des compagnies américaines qui vont offrir ce bénéfice en l'an deux mille. O.K. Ce qui est à mon point de vue une manière d'illustrer comment ça peut être appliqué dans une juridiction.

R- Et septièmement, la surveillance des tendances de la consommation du tabac, et de la morbidité et mortalité causées par le tabac... est un effort ici de comparer l'efficacité relative des stratégies nationales employées pour réduire le tabagisme.

Et il y a, huitièmement, la promotion de solutions de remplacement pour la production et le commerce du tabac, y compris le remplacement des revenus fiscaux provenant du tabac, qui est un élément, bien sûr, de la solution de ce problème-là, un élément qui est non négligeable.

Alors dans le contexte de la question qui m'était posée, Votre Seigneurie. De fait les mesures s'adressent pour l'essentiel à des actions sur l'environnement puisque -- et je le dis un peu plus loin

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dans mon mémoire -- on n'a pas réussi, en dépit d'investissements considérables, à changer substantiellement le caractère toxique de l'agent ici. De fait, quand on parle d'agent, et qu'on parle d'exposition -- on parle d'exposition au tabac; de fait, c'est un terme générique; il y a des milliers d'agents en cause. Et on n'a pas vraiment réussi à réduire la toxicité de ce produit-là. Donc il est pas étonnant que dans le programme de l'O.M.S., on trouve pas d'intervention qui s'applique pour l'essentiel à l'agent.

Il en est de même pour l'hôte. On n'a pas été capables jusqu'à maintenant d'imaginer des manières de réduire la susceptibilité de l'hôte à l'exposition à ces produits-là autrement qu'en réduisant l'exposition. Et là, de fait, il y a des éléments du programme qui s'appliquent à ceci. Puisque réglementant, par exemple, l'utilisation de la cigarette; en soi, dans la mesure où ça réduit l'exposition, ça produit un effet bénéfique sur la santé moyenne du groupe; et le simple fait, par exemple, de n'être pas exposé dans cette salle-ci, si on le reproduit sur des milliers d'individus, ça produit un effet mesurable à long terme sur la santé du monde, et, en soi, ça vaut la peine de rechercher cet effort-là.

Même les fumeurs eux-mêmes reconnaissent que ça

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réduit leur consommation, et c'est pour ça que c'est tellement important de réglementer l'utilisation. Pas pour casser... ou compliquer la vie des fumeurs, mais simplement parce que ça produit un bénéfice tangible à la santé, à des exposés, et puis, par extension, à la santé de ceux qui ne sont pas fumeurs.

LA COUR:

29/0096 Il est quatorze heures trente (14:30)... seize heures trente (16:30). C'est le printemps depuis dix (10) minutes. Très heureux de l'apprendre.

Me JOYAL:

J'ai le sourire, là, Votre Seigneurie. À quatre heures (16), je l'avais pas, mais là je l'ai.

LA COUR:

Demain matin... je veux seulement savoir, avoir une idée de combien de temps qu'il vous reste.

Me JOYAL:

Une (1) heure encore.

LA COUR:

Une (1) heure encore?

Me JOYAL:

Trois quarts d'heure. Quarante-cinq (45) minutes à une (1) heure.

LA COUR:

Et de votre côté?

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Me POTTER:

À peu près la même chose, Votre Seigneurie.

LA COUR:

Et de votre côté?

Me MITCHELL:

Je pense... bien on finira le matin en tout cas.

LA COUR:

C'est parce que j'aimerais... à ce moment-là, j'aimerais peut-être commencer à neuf heures trente (9:30) demain, parce que je dois m'absenter un peu plus tôt pour aller à... je dois aller à l'hôpital avec mon fils pour midi trente (12:30), et c'est à Longueuil.

Me JOYAL:

Alors ça va.

LA COUR:

Alors je dois quand même partir vers midi moins quart (11:45) pour être là pour midi trente (12:30).

Me JOYAL:

Moi, je serais même prêt à commencer à neuf heures et quart (9:15), Votre Seigneurie. Je sais que le docteur Turcotte est à l'hôtel.

Me POTTER:

Pour nous, ça va.

Me JOYAL:

J'aimerais peut-être mieux vous suggérer de commencer à

http://legacy.library.ucsf.edu/tid/ndr07a00/pdf
Support https://www.industrydocuments.ucsf.edu/docs/mgxl0001

neuf heures et quart (9:15). Comme ça, on sera certains de terminer...

LA COUR:

Pour en finir avec vous. Alors à neuf heures quinze (9:15) demain matin.

Me BAKER:

My Lord, just before we break. You recall, earlier in the week I gave you a list of witnesses with the order that they would be testifying. Although I don't have the document in front of me, I've left it in my office, I've done some verifying and we are going to invert the order of Dr. Best and Dr. Chandler and I wanted to let my friends know the official way as early a time as possible.

Me POTTER:

So Chandler would come on April ninth (9th)?

Me BAKER:

If things go according to schedule, but he will certainly be before Best.

LA COUR:

Okay, so he'll be before Best.

Me BAKER:

Just reverse the two (2), My Lord.

LA COUR:

Thank you.

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Me BAKER:

You're welcome.

AJOURNEMENT DE LA SÉANCE.

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